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STERILIZATION ABUSE: A PROPOSED REGULATORY SCHEME

*More Children From the Fit,
Less from the Unfit—That is the
Chief Issue of Birth Control.*¹

Sterilization, a permanent form of birth control,² is becoming one of the most popular methods, second only to the pill.³ In 1976, female sterilization became one of the ten most frequently performed operative procedures in the United States.⁴ This popularity is alarming because many of these sterilizations are performed without informed and voluntary consent to the procedure.

This Comment will explore sterilization abuse and its relationship to the philosophy of the population control movement. It then will discuss the constitutionality of state legislation attempting to prevent such abuse. The importance of state sterilization regulations in light of recent case law also will be presented. Finally, a model regulatory scheme will be proposed, and possible challenges by the medical profession to the proposed scheme will be analyzed.

1. T. LITTLEWOOD, *THE POLITICS OF POPULATION CONTROL* 16 (University of Notre Dame Press 1977) [hereinafter cited as LITTLEWOOD], citing M. SANGER, *BIRTH CONTROL REVIEW* 2 (May 1919).

2. Recently there have been attempts to reverse sterilization through microsurgery. See, e.g., Gomel, *Tubal Reanastomosis by Microsurgery*, 28 *FERTILITY AND STERILITY* 59 (No. 1, 1977). As of January 1978, only 75 cases of microsurgery reversals were reported. Thus, estimates of a 60% success rate based on these carefully selected cases are misleading. Schildkraut, *Sterilization: Now It's Simpler, Safer. Reversible? Maybe*, *GOOD HOUSEKEEPING*, Jan. 1978, at 164. The cost can be \$3,000 or more. *Id.* There simply is no reversible method that absolutely can be depended on. *Id.* Moreover, the reversal procedure can intensify the risk of an ensuing ectopic pregnancy, a life threatening condition. See Siegler & Perez, *Reconstruction of Fallopian Tubes in Previously Sterilized Patients*, 26 *FERTILITY AND STERILITY* 383, 386 (No. 5, 1975).

3. Westoff & Jones, *Contraception and Sterilization in the United States, 1965-1975*, 9 *FAM. PLAN. PERSPECTS* 153, 154-55 (No. 4, 1977). It is estimated that from 1960 to 1970 the number of sterilizations increased from 100,000 to 1,000,000 per year. Wood, *Psychosocial Aspects of Sterilization*, 16 *CURRENT PSYCH. THERAPIES* 303, 305 (1976) [hereinafter cited as *Psychosocial Aspects*].

4. Hysterectomy was the third most frequent operative procedure (678 per 1000) and fallopian tube sterilization was the ninth (420 per 1000). *DEPT OF SURGICAL PRACTICE OF THE AM. COLLEGE OF SURGEONS, SOCIO-ECONOMIC FACTBOOK FOR SURGERY* 1978, 33 (K. Kuntzman & R. Lance eds. 1978). Tubal ligation is one method of sterilization. It is accomplished by tying, obstructing, or removing the fallopian tubes. Traditional surgical techniques reach the tubes through the vagina or abdomen, and require a two to three day hospitalization. The newer endoscopic procedures can be performed on an outpatient basis. In this procedure, a tiny incision is made in the abdominal wall and the tubes are cauterized (burned) or clipped. Hysterectomy, on the other hand, is the removal of the uterus and it has a complication rate which is ten to twenty times higher than that associated with tubal ligations. Caress, *Sterilization: Women Fit To Be Tied*, 62 *HEALTH PAC. BULL.* 1, 2 (Jan./Feb. 1975) [hereinafter cited as *Fit To Be Tied*].

STERILIZATION
The Problem of Abuse

As of 1973, 2.2 million married persons were sterilized.⁵ Since unmarried persons also are sterilized, the total number probably is larger. Several studies indicate that the demographic incidence of sterilization has a disproportionate racial and economic impact.

For example, a 1972 study of the United States' contraceptive practices revealed that 32.5% of all black women had been sterilized as opposed to 11.6% of all white women.⁶ Another 1972 study noted that the combined sterilization rate for Blacks and Latin Americans was almost two-thirds higher than the rate for Caucasians.⁷ The same study discovered that non-white public assistance recipients were twice as likely "to elect" sterilization than white recipients,⁸ and public assistance recipients, as a group, were sterilized more than twice as often as non-recipients.⁹ Similar racial differences were detected in sterilization rates of married couples aged 15-44 in the 1973 study.¹⁰ A 1976 study found that low income women of both races aged 15-34 were sterilized more often than higher income women.¹¹

A 1976 government study also suggested that people of color may be frequent targets of subtle "pressure."¹² This report states that in four out of twelve Indian Health Service areas surveyed over 3,400 Native Americans were sterilized during a four-year period.¹³ The Government Accounting Office estimates that the number of persons actually sterilized was higher

5. NATIONAL CENTER FOR HEALTH STATISTICS, U.S. DEPT OF HEW, 25 MONTHLY VITAL STATISTICS REP. 3 (No. 7, Oct. 4, 1976) [hereinafter cited as MONTHLY VITAL STATISTICS]. The study also found that 33.8% of couples in the 36-40 age group were sterilized. *Id.*

6. Westoff, *The Modernization of U.S. Contraceptive Practice*, 4 FAM. PLAN. PERSPECTS. 9, 12 (No. 3, 1972).

7. The combined sterilization rate for Blacks and Latin Americans was 63% higher than anglo-women. Vaughan & Sparer, *Ethnic Group and Welfare Status of Women Sterilized in Federally Funded Family Planning Programs, 1972*, 6 FAM. PLAN. PERSPECTS. 224, 226 (No. 4, 1974).

8. *Id.* Among nonwhites, the aggregate sterilization rate for recipients was 19.7 per 1,000 as compared to 10.3 per 1,000 nonrecipients. *Id.* at 228.

9. *Id.* at 227. The sterilization rates were reviewed on the basis of welfare status without consideration of age or parity.

10. See MONTHLY VITAL STATISTICS, *supra* note 5, at 3.

11. Ford, *Contraceptual Use in United States 1973-1976*, 10 FAM. PLAN. PERSPECTS. 264 (No. 5, 1978). In the 15-24 age group, sterilizations increased among white and black low income married women from 5.3% in 1973 to an estimated 5.8% in 1976, while sterilizations decreased among higher income women from 3.8% to 3.5%. In the 25-34 age group, sterilizations increased by 10% in the low income group and 6.6% in the higher income group. In the 35-44 age group, however, low income sterilizations decreased and higher income sterilizations increased. *Id.* at 265. These years are not the primary childbearing years.

12. Report to Senator Abourezk from Comptroller General of the United States, November 4, 1976 (HRD-77-3) [hereinafter cited as GAO Report].

13. *Id.*

than reported.¹⁴ Many so sterilized believed the procedure was mandatory, not elective.¹⁵

The belief that sterilization is mandatory¹⁶ may be attributed to the absence of informed and voluntary consent. This type of manipulated consent to sterilization is the heart of sterilization abuse.¹⁷ As both literature and case law indicate, this abuse frequently takes place when women are approached for consent during labor,¹⁸ the postpartum period of

14. *Indian Sterilizations Told*, Chicago Sun Times, Nov. 1, 1976, at 2, col. 2 [hereinafter cited as *Indian Sterilizations*]. The numbers are actually higher since the report only covered four areas. Three thousand and one women of childbearing age (15-44 years) were sterilized. Some were under 21 years of age. GAO Report, *supra* note 12, at 4. Dr. Uri estimates that 25% of native American women have been sterilized. Miller, Miller & Szychenyi, *Native American Peoples on the Trail of Tears Once More*, AMERICA Dec. 9, 1978, 422, 423 [hereinafter cited as *Native American Peoples*].

15. *Native American Peoples*, *supra* note 14, at 422-23.

16. This experience has occurred not only with native American women, *see* note 15 and accompanying text *supra*, but also with low income individuals in general. *See* note 24 and accompanying text *infra*.

17. When a physician initiates the sterilization decision rather than the woman, the regret rate is reported to be 32%. Adams, *Female Sterilization*, 89 AM. J. OBSTETS. & GYN. 395, 401 (1964), *citing* Barnes & Zuspan, *Patient Reaction to Puerperal Surgical Sterilization*, 75 AM. J. OBSTETS. & GYN. 65, 70 (1958). Diane Nuckles, a counselor at the Special Care Center in Oakland, California, stated that in 1976 more than one out of every ten women who had been counseled and signed the consent form changed their minds before surgery. Affidavit of Diane Nuckles, Complaint in Intervention, Exhibit H at 1, California Medical Ass'n v. Lackner, No. 268099 (Cal. Super. Ct. April 28, 1978).

18. At Baltimore City Hospital, a study of 12 women between the ages of 18 and 21 revealed that all 12 women were given sterilization consent forms to sign minutes before a caesarean section operation. In almost all cases they were in active labor when approached and none had expressed a prior interest in sterilization. B. Rosenfeld, S. Wolfe, R. McGarrah, A HEALTH RESEARCH GROUP STUDY ON SURGICAL STERILIZATION: PRESENT ABUSES AND PROPOSED REGULATIONS 4-5 (Oct. 29, 1973) (unpublished research by the Health Research Group, a nonprofit public interest group in Washington, D.C.) [hereinafter cited as HRC STUDY].

An interview with U.S.C.-L.A. Hospital house staff about their medical school hospitals revealed that many women were pressured into sterilizations while under the stress and agony of childbirth. Sometimes the residents suggested sterilization during labor by asking the women whether they wanted to go through this pain again. Dreifus, *Sterilizing the Poor*, THE PROGRESSIVE, Dec. 1975, at 13, 15-17 [hereinafter cited as Dreifus]. In one doctor's affidavit, he stated:

I have . . . seen and documented continued pushing and hard selling of sterilization at every public hospital with which I have been associated. Sterilization by coercion was not an uncommon practice in these hospitals. Some of these practices consisted of asking women in labor if they wanted their 'tubes tied', approaching women immediately after childbirth . . .

Affidavit of Dr. Rosenfeld, Complaint in Intervention, Exhibit E at 3, California Medical Ass'n v. Lackner, No. 268099 (Cal. Super. Ct. April 28, 1978) [hereinafter cited as Rosenfeld's Affidavit]. This type of abuse has been reported in the case law. *See, e.g.,* Madrigal v. Quilligan, No. CV 75-2057-JWC (D. Cal., filed June 30, 1978); Relf v. Weinberger, 372 F. Supp. 1196, 1199 (D.D.C. 1974).

childbirth,¹⁹ while sedated,²⁰ or before or after an abortion.²¹ Some women also are offered an abortion in exchange for consenting to sterilization²² or are subjected to a hysterectomy for questionable reasons.²³ Sometimes they

19. From July 1968 to July 1970, the Women's Hospital of Los Angeles County Medical Center reported a 151% increase in tubal ligation sterilizations after delivery. See HRG STUDY, *supra* note 18, at 1. Dr. Wood, the past president of the Association for Voluntary Sterilization and a practicing obstetrician for thirty years, routinely offered postpartum sterilization to any indigent woman with three children. *Psychosocial Aspects*, *supra* note 3, at 307. See also *Downs v. Sawtelle*, 574 F.2d 1 (1st Cir. 1978); *Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977).

20. One resident at U.S.C.-L.A. Hospital stated that he made his "pitch" while sewing up the episiotomy when the anesthesia started wearing off. *Fit To Be Tied*, *supra* note 4, at 5.

21. Dr. Rosenfeld relates this eyewitness account of doctors:

[S]elling sterilization and abortion as a package deal, i.e., 'when we do your abortion, it would be good to get your tubes tied at the same time' (at the time of an abortion, a much fairer presentation of the options would be explaining that . . . deciding during the stress of unwanted pregnancy in a short period of time may not be ideal . . .).

Rosenfeld's Affidavit, *supra* note 18, at 3. Note that a vaginal tubal ligation performed in conjunction with an abortion has a 41.7% complication rate as compared to a 20.1% rate if the abortion is not performed. Tappan, *Kroener Tubal Ligation in Perspective*, 115 AM. J. OBSTETS. & GYN. 1053, 1054-55 (1973) [hereinafter cited as Tappan].

22. Nancy Stearns from the Center for Constitutional Rights reported cases of women being offered abortions in exchange for sterilization. Arrastia, *New Regulations for Sterilization*, 2 SEVEN DAYS 3, 13-14 (No. 2, 1978) [hereinafter cited as Arrastia]. Correspondence from Dr. D. B. Whitehouse to the British Medical Journal reveals that sterilization of young wives are often done in place of abortions. Dr. Whitehouse wrote that "[m]any of us . . . with a dislike of abortion, see tubal ligation as a simpler and more acceptable alternative, with the result that the number of these operations performed has rocketed in the past few years." 2 BRITISH MEDICAL JOURNAL 707 (June 19, 1971) (emphasis added). A former student from Wayne State Medical School in Detroit explained that sixteen year olds were sterilized if they had two children. He stated, however, that they did not perform many abortions since the residents did not like to do them. Dreifus, *supra* note 18, at 16.

23. A hysterectomy is the removal of the uterus or "womb". This surgical procedure can be approached from the vagina or the abdomen. *Fit To Be Tied*, *supra* note 4, at 2. The National Center for Health Statistics estimated that 794,000 women underwent hysterectomies in 1976. Caress, *Womb-Boom*, 77 HEALTH PAC. BULL. 13 (July/Aug. 1977) [hereinafter cited as *Womb-Boom*]. Hysterectomy solely for the purpose of sterilization is now routinely practiced at many hospitals. *Id.* at 14. It has a morbidity or complication rate of 22% and as many as 300-500 mortalities may occur per 100,000 hysterectomies. See Porter & Hulka, *Female Sterilization in Current Clinical Practice*, 6 FAM. PLAN. PERSPECTS. 30, 35 (No. 1, 1974). It is important to note that hysterectomy is a "drastic sterilization procedure" which removes an organ which has considerable value for ego image and a woman's sense of identity. *Id.*

That hysterectomy often is performed for questionable medical reasons illustrates towards whom it is directed and for what reasons. Two University of Kentucky doctors suggested that vaginal hysterectomy might be the sterilization procedure of choice for the indigent, multiparous (multiple pregnancies) patient. Nagell & Roddick, *Vaginal Hysterectomy as a Sterilization Procedure*, 111 AM. J. OBSTETS. & GYN. 703, 707 (1971). In response to these doctors' claims that hysterectomy for socio-economic reasons during the ages of 20-39 was valuable to prevent the high incidence of cancer associated with this population, the editor of Family Planning Perspectives stated:

It may be pointed out, in case it did not occur to Drs. Van Nagell and Roddick, that indigent populations are at significantly higher risk of developing a great many ailments than more affluent populations, and that preventive surgery aimed at the

are threatened with withdrawal of welfare assistance,²⁴ not told of alternative birth control methods,²⁵ or are given misinformation.²⁶ Furthermore,

social conditions (poverty, malnutrition, poor medical care, slum housing, etc.) which causes these inequities may be both more sensible and more humane than proposals to hack 'preventively' at future possibly offending flesh.

4 FAM. PLAN. PERSPECTS. 1, 5 (No. 3, 1972).

An example of a hysterectomy done for a questionable reason is a hysterectomy performed for training purposes. The Surgical Boards, including the American Board of Surgery and various sub-specialty Boards (for example, Obstetrics and Gynecology), stipulate the number of operations the physician-candidate must assist or perform. This leads to the need to "sell" these operations. HRG STUDY, *supra* note 18, at 2. Often surgeons in training learn to operate by performing surgery on low income individuals. *Id.* at 3. One resident stated "[i]f you can talk her into it, get the papers and have her sign them. . . . If she won't agree to a hysterectomy, get me and I'll talk her into it." *Id.* A resident at Boston City Hospital is reported to have said "[w]e like to do a hysterectomy, it's more of a challenge You know, a well-trained chimpanzee can do a tubal ligation . . . and it's good experience for a junior resident . . . good training." *Id.* Apparently, the health of the patient is not a factor. A hysterectomy (all types) has a 56.1% to 71.4% complication rate as compared to a 4.7% rate in laproscopic tubal ligation. Tappan, *supra* note 21, at 1054-55. One physician notes that although hysterectomy is frowned upon as a general sterilization procedure because of the significant risk and morbidity, "[r]ecent enthusiasm for performing sterilization by elective vaginal hysterectomy and cesarean hysterectomy in the name of residency training is commonplace in some university hospitals with small surgical census" De Alvarez, *Panel Discussion on Contraception & Sterilization*, 89 AM. J. OBSTET. & GYN. 392, 394 (1964) [hereinafter cited as De Alvarez].

One controlled study found that tubal ligation has a better long term psychological response than hysterectomy. The authors postulated that tubal ligation has a less drastic effect on body integrity and allows a fantasy of future pregnancies. This fantasy occurred almost uniformly in those women sterilized by tubal ligation, but rarely in those sterilized by hysterectomy. Barglow, Gunther, Johnson, & Meltzner, *Hysterectomy and Tubal Ligation: A Psychiatric Comparison*, 25 OBSTETS. & GYN. 520, 525 (1965) [hereinafter cited as Barglow].

24. In *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974), the court noted that "an indefinite number of poor people have been improperly coerced into accepting sterilization operations under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Id.* at 1199 (footnote omitted).

25. Adequate information about other birth control methods is an important factor in informed consent. Knowledge of the risks and benefits of methods other than sterilization enables a person to make an informed decision about birth control.

26. A former medical student at University of California-San Francisco General Hospital relates the following experience of omitting information: "[I]f the patient asked, yes, she'd [sic] be told it was permanent. If there was a big rush, the staff wouldn't bother." Dreifus, *supra* note 18, at 17. Another former medical student from Bellevue Hospital in New York admitted that many women there believed their tubes could be untied. *Id.* Dr. Rosenfeld noted that physicians rarely stressed that a tubal ligation actually involves removal or destruction of part of the fallopian tube and therefore cannot later be "untied." Rosenfeld's Affidavit, *supra* note 18, at 4. In one study, five out of twenty women admitted to Baltimore City Hospital for tubal ligation were told that the sterilization procedure was reversible or that there was no other effective method of birth control. When these five women were told that the procedure was irreversible, they withdrew consent. HRG STUDY, *supra* note 18, at 6.

Dr. Rosenfeld also reports a practice of exaggerating the dangers of a future pregnancy to the point of distortion. Rosenfeld's Affidavit, *supra* note 18, at 3. Ms. Hernandez, an attorney, reported that her mother was told after delivery that she would have to get her "tubes tied" because if she had another baby, she would die. A second opinion revealed the falsity of this

women often are not given sterilization information in their native language²⁷ and, therefore, are asked to sign consent forms which they cannot understand. In some cases, necessary medical services,²⁸ welfare benefits,²⁹ and, more recently, employment³⁰ have been conditioned upon acceptance of sterilization.

These practices reveal that many persons considering sterilization have no access to all the information necessary to give fully informed consent to a permanent and irreversible procedure. Sterilization abuse has a salient history indicating a disproportionate impact upon the poor and minorities.

Population Control

Sterilization without voluntary and informed consent began with the eugenics movement early in the twentieth century.³¹ According to some commentators,³² the eugenics movement, which culminated in sterilization

claim. Dreifus, *supra* note 18, at 17. A former medical student admitted that "the ward patients weren't [sic] given as much information on sterilization as the private patients." *Id.*

27. As a former medical student at New York's Bellevue Hospital described it: "There was a large Puerto Rican population and I think a lot of women didn't know the full consequences of what was happening to them. There was a language problem." Dreifus, *supra* note 18, at 17. See also *Madrigal v. Quilligan*, No. CV 75-2057-JWC (D. Cal., filed June 30, 1978).

28. See *Downs v. Sewtelle*, 574 F.2d 1 (1st Cir. 1978); *Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977).

29. See *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974). See also *Downs v. Sawtelle*, 574 F.2d 1 (1st Cir. 1978).

30. See Comment, *Employment Rights of Women in the Toxic Workplace*, 65 CALIF. L. REV. 1113 (1977).

31. The objective of this movement was race improvement; its proponents applied Mendel's law of heredity to humans. They believed that criminality, delinquency, mental illness, epilepsy, immorality, and pauperism were defective characteristics transmitted hereditarily. Sir Francis Galton, the founder of this movement, coined the term "eugenics." He divided the concept into two classes: (1) positive eugenics, directed at inducing those of superior stock to marry others with similar qualities to produce children of superior quality, and (2) negative eugenics, directed at suppressing reproduction by those who it was feared would pass on undesirable characteristics to their offspring. Sterilization, segregation, and education were the proposed means which would reduce reproduction. The advancement of salpingectomy (removal of the fallopian tubes) and vasectomy (obstruction of the vas deferens) as surgical sterilization procedures coincided with the interest in eugenics theory. See, e.g., Gaylord, *The Sterilization of Carrie Buck*, 83 CASE & COMMENT 18, 19 (No. 5, 1978) [hereinafter cited as Gaylord].

As late as 1964, eugenic indications for population control were described as "curtailing reproduction in the feeble-minded, insane, and those with major genetic disease. The end may be technically achieved by . . . sterilization, or by institutional 'sterilization' by the detention of a patient, particularly the female, until she has reached an age too old to reproduce." De Alvarez, *supra* note 23, at 393 (emphasis added). As early as the 1940's, geneticists suggested that, with some exceptions such as certain genetic diseases, such traits were not inheritable. Gaylord, *supra* at 20.

32. Gaylord, *supra* note 31, at 19. See also LITTLEWOOD, *supra* note 1, at 113-15; Paul, *The Return of Punitive Sterilization Proposals*, 3 L. & SOC'Y REV. 77 (1968) [hereinafter cited as Paul].

laws for the unfit,³³ has spawned a new movement: population control.³⁴ Population control is premised upon the theory that world problems, such as inadequate food supplies, poverty and energy depletion, are a consequence of overpopulation.³⁵ Government and society, therefore, have demonstrated an interest in solving the world's problems by attempting to limit population growth.³⁶ For example, the Federal Office of Population is seeking to pro-

33. It is not within the scope of this Comment to discuss eugenic sterilization and laws relating thereto. These laws were designed to prevent America from being inundated by socially undesirable classes or categories of persons that state legislators believed to be a threat to the survival and stability of the nation. Paul, *supra* note 32, at 78. See generally Ferster, *Eliminating the Unfit—Is Sterilization the Answer?*, 27 OHIO S.C.J. 591 (1966); Murdock, *Sterilization of the Retarded: A Problem or a Solution?*, 62 CALIF. L. REV. 917 (1974); Neuwirth, *Capacity, Competence, Consent; Voluntary Sterilization of the Mentally Retarded*, 6 COLUM. HUMAN RIGHTS L. REV. 447 (1974). The infamous Supreme Court decision of *Buck v. Bell*, 274 U.S. 200 (1927), upheld the validity of the Virginia Sterilization Act, which was patterned after a nationally proposed model Eugenical Sterilization Act.

34. One author offered the following connection between the eugenics movement and the present population control movement:

Recently, there has been a renewal of interest in compulsory sterilization; not for eugenic purposes but as a population control measure. . . (Malthus proposed cutting off doles to poor families and 'letting the laws of nature, which are the laws of God' resolve the overpopulation for the poor.) (citation omitted).

. . . Within the past two decades, a number of measures contributory to population control . . . have been tried. . . And there are even proposals to limit the size of welfare benefits regardless of family size, adopting Malthus' proposed remedy of making Poor Laws stricter.

Gaylord, *supra* note 32, at 20. See also LITTLEWOOD, *supra* note 1, at 114.

35. See Shaw, *Procreation and the Population Problem*, 55 N.C.L. REV. 1165 (1977) [hereinafter cited as Shaw]. LITTLEWOOD, *supra* note 1, at 6, describes various attitudes of society toward "overpopulation" by the poor. The first is the "Equal Opportunity Concept" in which Americans who can afford to pay their own medical bills generally have the capacity to regulate their family size, but the poor are unable to control family size and suffer untold undesirable consequences. Littlewood notes that historically, this "hard core of support" for organized birth control had been bolstered in the United States by the very rich who feared that the system would be threatened by lower class overpopulation. *Id.* The second attitude he describes is "Quality-of-Life." It is espoused by those who are "comfortably fixed" and worried about metropolitan overcrowding and environmental pollution. A few, he notes, are sincerely sickened by the world population-hunger problem, and want the U.S. to set a good example for the rest of the world even though this is a "food-exporting nation with serious overpopulation only in a few metropolitan centers." *Id.* at 7. The third attitude belongs to the "eugenic engineers" who believe that "undesirables—blacks particularly—are propagating wildly, that they won't support themselves out of sheer laziness, and that this expanding 'underclass' is determined to transfer wealth from productive workers to parasitic loafers." *Id.*

36. See *Psychological Aspects*, *supra* note 3, at 304; Shaw, *supra* note 35, at 1167. The government's interest in limiting population growth became policy in 1970 when the Public Health Service Act was amended by Title X of Population Research and Voluntary Family Planning Act Program, 42 U.S.C. §§ 300 to 300a-6 (1970). This amendment authorized governmental grants for contracts with public or private entities to "assist in developing and making available family planning and population growth information." *Id.* at § 300a(3). Such a grant or contract for a family planning project could be made only upon assurances that priority would be given in the project to furnishing these services to low income families at no charge. *Id.* at §§ 300a-4(c)(1), (2).

vide the means by which one quarter of the fertile *women* in the world can be sterilized.³⁷ The director of this office has cited several reasons why the United States should assume leadership in world population control, including the notion that such control will increase the standard of living in underdeveloped countries.³⁸ He also has stated that population control is necessary to maintain the "normal operation of U.S. commercial interests around the world."³⁹

The theory that the eugenics movement has progressed into an economically motivated population control movement is evidenced by their parallel philosophies and by the similarity of the proposed sterilization laws to those adopted at the height of the eugenics movement. For example, there have been various state legislative proposals to sterilize mothers of illegitimate children who receive Aid to Families with Dependent Children (AFDC).⁴⁰ Another illustration of the close connection between these

A more explicit example of governmental attempts to decrease population in order to solve "population problems" is described in an introduction to an HEW publication:

While the emphasis on voluntary family planning as a health measure of considerable significance for both the individual family and the community is readily accepted, *the interest of public welfare departments has also focused attention on the added dimension of family planning as a social measure, since the availability of family planning services is a crucial part of community efforts to reduce poverty and dependency.* . . .

The support of the U.S. Federal and State governments for family planning and contraception served as a powerful impetus to the proliferation of important new programs in the mid-1960's. . . .

The passage of [the Family Planning Services and Population Research Act of 1970] and the influx of Federal Funds led to the *rapid increase* in number of new family planning programs.

NATIONAL CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEW, DEVELOPMENT OF THE NATIONAL INVENTORY OF FAMILY PLANNING SERVICES 2-3 (Pub. No. 76-1312 Series 1, No. 12, January 1976) (emphasis added). See also Note, *Involuntary Sterilization: An Unconstitutional Menace to Minorities and the Poor*, 4 N.Y.U. REV. L. & SOC. CHANGE 127 (1974).

Birth rate records reveal that attempts to limit population have been successful. In 1972, there was a significant drop in the birth rate, and in 1974 a record low was reached. LITTLEWOOD, *supra* note 1, at 65-66.

37. St. Louis Post-Dispatch, April 22, 1977, at 1, col. 1 (emphasis added).

38. *Id.*

39. *Id.* After revealing the government's economic motives, he noted that "without our trying to help these countries with their economic and social development, the world would rebel against the strong U.S. commercial presence. The self-interest thing is a compelling element." *Id.*

40. Paul, *supra* note 32, at 78. The states considering such punitive sterilization proposals were California, Delaware, Georgia, Illinois, Iowa, Louisiana, Maryland, Mississippi, North Carolina, and Virginia. *Id.* at 79. State Representative David H. Glass of Tosciusko, Mississippi, sponsor of the legislation in that state, stated that "the Negro woman, because of child welfare assistance is making it a business, in some cases of giving birth to illegitimate children The purpose of my bill was to try to stop, or slow down *such traffic at its source.*" *Id.* at 89 (emphasis added). Richard Friske, a Michigan state legislator, probably reflected the views of many of his colleagues when he stated that "there is a need for curbing the growth of the *drone population that weakens our society. Educated, propertied Americans need a vigorous pro-*

movements is the notion that the "welfare dilemma" means taxpayers' rights are ignored without any obligation imposed upon welfare recipients to stop increasing the public burden by indulging in hyperfertility.⁴¹

A proposed solution to "clearing up the welfare mess"⁴² is to decrease the poor population by routinely offering postpartum sterilization to all pregnant women falling within lower socioeconomic groups.⁴³ The population explosion rationale, most often directed at the poor, blames the victim of society's ills for society's ills.⁴⁴ Herein lies the threat of sterilization abuse: the popu-

natalist outlook, but the tax pressure of the middle-class all but forbids this . . . while the ignorant dependent elements multiply." LITTLEWOOD, *supra* note 1, at 81-82 (emphasis added). Of all these states, Maryland introduced the strongest proposal to curb illegitimacy. Maryland Senate Bill No. 91 would have subjected a woman "convicted" of giving birth to more than two illegitimate children to a fine of one thousand dollars and/or imprisonment not to exceed three months. Paul, *supra* note 32, at 84. In addition, she could be declared morally unfit. The state could then permanently remove her children from her care and control, and permanently bar her from receiving welfare payments. There was also a provision that called for mandatory sterilization. Perhaps the most frightening aspect of this proposed bill was that it passed in the Maryland Senate by a vote of 23 to 3. Fortunately, it was defeated in the House of Delegates. *Id.* at 84-85.

House Bill No. 180, introduced into the Mississippi legislature in 1964 by Representative W.B. Meek, made being a parent of a second or subsequent illegitimate child a felony punishable by one to three years in the state penitentiary. Representative McCullough added an amendment which would have allowed a convicted parent to submit to sterilization in lieu of imprisonment. *Id.* at 89-90. Perhaps most indicative of the overlapping between the eugenics and population control movements was a bill introduced in North Carolina that extended the existing eugenics sterilization law to include grossly sexually delinquent persons. Giving birth to a second or subsequent illegitimate child was grounds for a hearing before the State Eugenics Board, which could order sterilization. Upon birth of a third illegitimate child, the Eugenics Board was mandated to order the mother to show cause why she should not be found a grossly sexual delinquent and sterilized. *Id.* Thus, it indeed does appear that sterilization continued to have symbolic force in the minds of some for saving America from shame and poverty as it did sixty years earlier when legislators were saving America from mental deficiencies.

While earlier arguments differed from the present revival in their stress on biological, rather than economic determinism, both rely on a notion of fitness as a prerequisite for procreation. "Whereas the earlier eugenic efforts were aimed at cutting off the 'defective germ plasm' of the American people before it 'drowned' us, current efforts would be aimed at cutting off *both* the defective germ plasm and welfare payments in order to avoid strangulation." *Id.* at 101. At least some would like to cut off the ability to reproduce to achieve both results. Paul quite accurately predicted that compulsory sterilization would be replaced with consent procedures and increased state and federal efforts to institute cash programs in birth control information and services. *Id.* at 102. As was noted in *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974), "[t]he dividing line between family planning and eugenics is murky . . . the secretary, through . . . regulations . . . seeks to sanction one of the most drastic methods of population control - the involuntary irreversible sterilization of men and women." *Id.* at 1204.

41. *Psychosocial Aspects*, *supra* note 3, at 306.

42. *Fit To Be Tied*, *supra* note 4, at 11.

43. *Psychosocial Aspects*, *supra* note 3, at 307. Sterilization would put an end to the "frightening increase in crime which may be the result of irresponsible and involuntary parenthood compounded by neglect and rejection of the child." *Id.*

44. The following view of Dr. Curtis Wood, the past president of the Association for Voluntary Sterilization, an organization active in the population control movement, is an example of this type of rationale:

lation control philosophy promotes the elimination of the lower economic class and minorities, the "unfit" of our society.⁴⁵ This danger was recognized as early as 1942 by Justice Douglas who described sterilization as the power which "[i]n evil or reckless hands . . . can cause races or types which are inimical to the dominant group to wither and disappear."⁴⁶ It is submitted that regulation of informed consent to sterilization is necessary to affirmatively protect against involuntary sterilization. Such practices are not

People pollute and too many people crowded too close together cause many of our social and economic problems. These, in turn, are aggravated by involuntary and irresponsible parenthood. As physicians we . . . also have an obligation to the society of which we are a part. The welfare mess, as it has been called, cries out for solutions, one of which is fertility control.

Fit To Be Tied, *supra* note 4, at 11.

It is significant that Dr. Curtis sees the physician's responsibility to society as an obligation to solve the welfare mess by fertility control. The implications of a population control policy aimed at the poor are tremendous, particularly when concurrent and tangible efforts to increase their life chances are absent. The National Medical Association, an organization of black physicians, was suspicious of family planning programs for this reason. They preferred a comprehensive health care program with family planning as only one part of the package. LITTLEWOOD, *supra* note 1, at 118. *See also* note 9 *supra*.

45. Littlewood believed that:

Behind all the fashionable rhetoric about ecological purity, backyard gardens, freedom of opportunity, maternal health, and long lines at movie houses stood the unpleasant political sociology of class and race. The policies of the 1960s and 1970s were aimed at lowering the fertility of the poor and the uneducated—particularly of Blacks and Latin Americans. If the objective is to check population growth as such, then the sensible policy would be to start with 'that segment of the population which already possesses motivation and technical competence in fertility control.'

LITTLEWOOD, *supra* note 1, at 66-67, quoting H. Yuan Tien, sociologist at Ohio State University. Littlewood also quoted a religious leader's belief that "[o]ur Catholic leadership has been wooed, unsuccessfully thank God, on many levels with the promise that 'we will leave your people alone. The proliferating Negro is our target.' " LITTLEWOOD, *supra* note 1, at 77, quoting Monsignor Rice.

This is not to say that middle class women are not subjected to sterilization abuse. This abuse, however, may take a more subtle form, as when a man is seeking a vasectomy and he is told that his wife should be sterilized instead. For example, in 1976 Dr. Curtis Wood advocated that physicians perform sterilizations on women rather than men for the following reasons:

First, because it is the woman who endures most of the mental and physical burdens of producing and rearing the child while the man is out trying to make a living . . . Second, women still menstruate . . . and are much less apt to have undesirable psychological side effects from the procedure than are men. . . .

The final and by far most important reason is. . . . [w]hen a marriage breaks up, the court usually awards the children to the wife. If she remarries *she tends to marry an older man, a widower, or divorcee*, who has probably experienced the joys and sorrows of fatherhood and *does not wish to begin all over again with a new crop of babies when he has his new wife's children to care for*. The husband, on the other hand, *tends to marry a younger woman* who has not been married before and wants her husband to have a reversal so she can become a mother.

Psychological Aspects, *supra* note 3, at 305-06 (emphasis added).

46. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (Douglas, J., writing for an unanimous Supreme Court).

only abusive, but may result in the inability to exercise a constitutional right—the right to procreate without governmental interference.⁴⁷

*Constitutionality of Regulations
Preventing Sterilization Abuse*

In *Skinner v. Oklahoma*,⁴⁸ the United States Supreme Court held that procreation is fundamental among the basic civil rights.⁴⁹ The Court found that a criminal statute which mandated sterilization of habitual felons encroached upon this right,⁵⁰ since it operated as an invidious discrimination in violation of the equal protection clause of the fourteenth amendment.⁵¹ In recognizing that procreation is fundamental to “the very existence and survival of the race,” the Court characterized sterilization as an “irreparable injury” and a “permanent deprivation of liberty.”⁵²

47. *Id.* The following argument assumes that the requisite state action is present. *See, e.g.*, *Reitman v. Mulkey*, 387 U.S. 369 (1967) (prestige or authority of state encourages or supports private action which violated constitutional rights); *Burton v. Wilmington Parking Auth.*, 365 U.S. 715 (1961) (the state is significantly involved in the injury as a joint partner); *Shelley v. Kraemer*, 334 U.S. 1 (1948) (although a racially restrictive covenant is private action, it is enforced by the state through its courts).

48. 316 U.S. 535 (1942).

49. *Id.* at 541.

50. *Id.* at 536. The statute defined a habitual criminal as one who has been convicted of a felony involving moral turpitude twice in the courts of Oklahoma or in the courts of another state and thereafter convicted of such a felony and sentenced to prison. *Id.* The defendant had previously been convicted of stealing chickens and robbery with firearms, and was ordered to submit to sterilization after another conviction for stealing chickens. *Id.* at 537. The Supreme Court reasoned that the nature of larceny and embezzlement were intrinsically the same and the promotion of sterilization for one but not the other was not constitutionally justifiable. *Id.* at 539. Thus, *discrimination*, not sterilization, in the statute's classification scheme was held to be unconstitutional. The *Skinner* Court relied on *Buck v. Bell*, 274 U.S. 200 (1927), in reaching its decision on equal protection grounds. 316 U.S. 535, 539-42. In *Buck*, the Supreme Court upheld a compulsory sterilization ordered under an eugenic statute. Justice Holmes wrote:

It is better for all the world, if instead of waiting to execute degenerate offspring for crime, to let them starve off for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that compulsory vaccination is broad enough to cover cutting the Fallopian tubes.

274 U.S. 200, 207 (1927) (Marshall, J., dissenting). As Justice Marshall stated: “*Skinner* does not impune the continuing validity of *Buck v. Bell*. . . .” *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1, 100 (1973) (Marshall, J., dissenting). For an excellent discussion of this *see* Brown, Book Review, 24 EMORY L.J. 1037, 1055-61 (1975) (CASE HISTORIES, INTEREST GROUP LITIGATION AND MR. JUSTICE HOLMES: SOME UNEXPLORED QUESTIONS ON PSYCHO-POLITICAL BEHAVIOR).

51. The Court noted that the statute exempted those persons convicted of embezzlement from its operation even though, according to the laws of Oklahoma, the crime of embezzlement was intrinsically the same in quality as the crime of larceny. Consequently, the statute imposed unequal treatment on criminals whose crimes were essentially equivalent. *Skinner v. Oklahoma*, 316 U.S. 535, 539 (1942).

52. *Id.* at 541.

Recent Supreme Court decisions have also sought to protect the right to procreate. The right to be free from governmental intrusion in the child-bearing decision-making process was recognized in *Roe v. Wade*,⁵³ where the Court held that the fundamental right to privacy encompassed the decision to seek an abortion. *Eisenstadt v. Baird*⁵⁴ also held that the right to privacy included the right of an individual to be free from unwarranted governmental intrusion in so fundamental a decision as whether to "bear or beget a child."⁵⁵

Given the extent and nature of sterilization abuse,⁵⁶ including its encroachment upon this right to procreate, the state has a compelling interest in enacting regulations preventing such abuses. Thus, regulations mandating informed consent to sterilization would not constitute an "unwarranted governmental intrusion" in violation of the fundamental right to privacy.⁵⁷ Unlike outlawing abortion, regulating sterilization is not a governmental intrusion because it does not force a woman to bear or not bear a child.⁵⁸ This regulation would only ensure that the decision whether or not to procreate is made with informed and voluntary consent. Thus, such a state law would provide what is clearly necessary protection and should be found constitutional.⁵⁹

53. 410 U.S. 113 (1973). Although the right to privacy is not specified in the constitution, it is recognized as a fundamental right which emanates from various constitutional provisions. *Griswold v. Connecticut*, 381 U.S. 479 (1965). In *Griswold*, the Supreme Court explained that the right to privacy is a peripheral right emanating from several specific amendments contained in the Bill of Rights. *Id.* at 482-83. A long line of cases establish the right to privacy: *Roe v. Wade* 410 U.S. 118 (1973) (abortion); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation).

54. 405 U.S. 438 (1972). The *Eisenstadt* Court held that a law which discriminated against two classes of persons, those married and those unmarried, violated the fundamental interest in privacy under the equal protection clause.

55. *Id.* at 453.

56. Moreover, sterilization abuse has occurred with the use of federal funds. See *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974).

57. This challenge would probably be made in the context of interference with the doctor-patient relationship.

58. Unlike abortion, which is the only means of preventing birth after conception, sterilization is one of many ways of preventing pregnancy before conception. Therefore, sterilization regulations do not infringe upon the privacy rights recognized by *Roe v. Wade*, 410 U.S. 118 (1973).

59. It should be noted, however, that several suits have been brought against hospitals establishing a "right" to sterilization without unnecessary restrictions. *Hathaway v. Worcester City Hosp.*, 475 F.2d 701 (1st Cir. 1973); *McCabe v. Nassau County Medical Center*, 453 F.2d 698 (2d Cir. 1971). These hospitals restricted access to sterilization relying on the American College of Obstetricians and Gynecologists (ACOG) restrictions. Note, however, that ACOG dropped its recommendations restricting access to sterilization in 1969. These restrictions included the age-parity formula. That formula allowed sterilization of women only if their number of children multiplied by their age equaled one hundred and twenty. In addition two doctors' signatures plus a psychiatric consultation were required before sterilization. *Fit To Be Tied*, *supra* note 4, at 4. Thus, these restrictions had nothing to do with health or informed consent.

THE NEED FOR STATE REGULATION

The need for state regulation consistent with, but stricter than, existing federal legislation⁶⁰ is evidenced by the lack of compliance with federal rules.⁶¹ Moreover, the federal mandates only apply to federally funded sterilizations while state regulation could apply to all sterilizations. Furthermore, individual malpractice actions are an inefficient means to prevent sterilization abuse since these necessarily are brought after sterilization. Surely no damage award could adequately compensate for the loss of the ability to procreate. Additionally, it is possible that such loss may not be compensated since courts sometimes inconsistently interpret the rights and remedies involved.⁶² These criticisms, directed toward the need for state legislation, will be discussed in the following two sections.

Regulating Federally Funded Sterilization
Relf v. Weinberger

The existence of federally funded involuntary sterilization was recognized in *Relf v. Weinberger*,⁶³ which involved a class action challenge to the then existing Department of Health, Education, and Welfare (HEW) sterilization guidelines. The district court held that the regulations were arbitrary and unreasonable because they failed to implement the Congressional command that participation in federally funded family planning services be volun-

Many legal writers advocate free access to sterilization and refute the need for regulations. See Kindregan *State Power Over Human Fertility and Individual Liberty*, 23 HASTINGS L.J. 1401 (1972); Pipel, *Voluntary Sterilization: A Human Right*, 7 COLUM. HUMAN RIGHTS L. REV. 105 (1975); Shaw, *supra* note 35; Torbes, *Voluntary Sterilization of Women as a Right*, 18 DEPAUL L. REV. 560 (1969). These writers challenged the age-parity formula as interfering with the fundamental right to decide whether to bear or beget a child. The age-parity formula did interfere with this right. When sterilization abuse, however, is accomplished with federal funds, it constitutionally interferes with the right to procreate and consequently a balance is needed. Regulating informed consent is that balance. See notes 64-68 and accompanying text *infra* for a discussion of *Relf v. Weinberger*. See also note 63 *infra*. The statute in the states authorizing sterilizations do not regulate them. Most were enacted to clarify legal uncertainties regarding voluntary contraceptive sterilization by pronouncing it not contrary to public policy. Comment, *The Doctor, The Patient and The United States Constitution*, 25 U. FLA. L. REV. 327, 339 (1973). *Hathaway v. Worchester City Hospital*, 475 F.2d 701 (1st Cir. 1973), and its progeny established the right to sterilization and eliminated the age-parity requirements. *Hathaway* held that the hospital's "unique ban" on sterilization violated the equal protection clause of the fourteenth amendment because no other surgical procedure was banned. *Id.* at 706. The court also found that non-therapeutic procedures of equal risk were performed and thus, the hospital could not refuse to perform sterilizations on these grounds as such refusal interfered with a fundamental right. *Id.* An argument can be made that this case should not apply to the regulation of sterilization since the regulations curb violations of the fundamental right to procreate; they do not interfere with it. The regulations ensure informed decisions whether or not to bear or beget a child.

60. 43 Fed. Reg. 52,148 (1978) (to be codified in 42 C.F.R. § 50.202).

61. See notes 82-92 and accompanying text *infra*.

62. See notes 95-118 and accompanying text *infra*.

63. 372 F. Supp. 1196 (D.D.C. 1974).

tary.⁶⁴ The court found "uncontroverted evidence" that an indefinite number of people receiving federal assistance were coerced into sterilizations under the threat of welfare assistance withdrawal.⁶⁵

As the court in *Relf* noted, even a fully informed person cannot make a "voluntary" decision about sterilization if he or she is subjected to coercion from doctors or project officers.⁶⁶ The *Relf* court defined "voluntary" to mean that an individual has the information necessary to make a rational decision regarding sterilization.⁶⁷ Thus, as a result of the *Relf* decision, federally assisted family planning sterilizations are permissible only with the voluntary, knowing, and uncoerced consent of a competent person.⁶⁸

64. *Id.* at 1201. Although the court did not decide the case on constitutional grounds, it stated that involuntary sterilizations directly threatened the constitutional right to privacy. *Id.* at 1201, citing *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

Statutory authority for federal funding of family planning services, including sterilization, is given to HEW in various titles of the Social Security Act which are codified at 42 U.S.C. §§602(a)(15), 705(a)(8), 1396a (a)(13), 1396d(a)(4)(c), 1397a(a)1 (1976). Additional Congressional authorization is conferred in the Public Health Service Act, codified at 42 U.S.C. §§ 247d (a), (b), (c); 254c(b), (1), (c); 300(a) (1976).

Three subdivisions of HEW are responsible for administering programs which involve the funding of sterilization. These are the Medicaid Bureau of the Health Care Financing Administration (HCFA), the Administration for Public Services (APS) of the Office of Human Development, and the Public Health Service (PHS). While the requirements for qualification of federal funds are the same for programs under the Social Security Act and the Public Health Service Act, the regulatory mechanism differs according to which subdivision administers the funding. HCFA and APS condition federal reimbursement to state agencies upon compliance by the health care provider with the federal guidelines. PHS funds certain programs such as Indian health centers and community health centers directly. It regulates by making the requirements a condition precedent to the grant of funds. 43 Fed. Reg. 52,148 (1978) (to be codified in 42 C.F.R. § 50.202).

65. *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974). Moreover, the court noted that patients receiving medical assistance at childbirth had been the most frequent targets of this type of pressure. Indeed, one of the plaintiffs was refused medical assistance by her physician unless she consented to be sterilized after childbirth. *Id.*

66. *Id.* at 1203. There have been legislative attempts to validate this type of coercion. In 1972, bills introduced in five state legislatures offered cash incentives for sterilization to welfare recipients or denied welfare payments to unsterilized women with one or two illegitimate children. The Illinois and New Hampshire proposals offered cash incentives, while Indiana, Ohio, and Tennessee would have denied benefits. None of the bills passed. Eliot, *Fertility Control and Coercion*, 5 FAM. PLAN. PERSPECTS. 132 (No. 5, 1973).

At least some members of the medical profession support the legislature in its attempt to encourage welfare recipients into the "election" of sterilization. Planned Parenthood did a pilot survey of 226 physicians in Detroit, Grand Rapids, Memphis, and West Virginia. The results showed 34% favored withholding public assistance for any illegitimate children after the second child and 30% favored total withdrawal of welfare benefits if the mother refused sterilization. Silver, *Birth Control and the Private Physician*, 4 FAM. PLAN. PERSPECTS. 42, 44 (No. 2, 1972).

Moreover, many doctors "encourage" sterilization for low-income and welfare mothers because they believe that the poorer the woman, the less likely she is to use other methods successfully. *Physician Attitudes: MDs Assume Poor Can't Remember to Take Pill*, 1 FAM. PLAN. DIG. 3-4 (Jan. 1972). One physician-participant in a panel discussion noted that the area of population control was a "realm of responsibility for all gynecologists". See De Alvarez, note 23 *supra*.

67. *Relf v. Weinberger*, 372 F. Supp. 1196, 1202 (D.D.C. 1974).

68. *Id.* at 1201.

To ensure such consent, the court ordered HEW to promulgate new regulations requiring that sterilization decisions be voluntary.⁶⁹ Pursuant to this order, HEW released regulations in 1974 which mandated informed consent in sterilization decisions.⁷⁰ Due to criticisms⁷¹ and studies which indicated a lack of compliance with the 1974 regulations,⁷² HEW proposed new sterilization rules in 1977⁷³ which were adopted in 1978.⁷⁴ These rules require a "thorough" explanation of the specific procedure to be performed, including the attendant risks and benefits and a description of alternative birth control methods.⁷⁵ In addition, notice must be given that the sterilization decision will not affect any federal benefits.⁷⁶ A thirty day waiting period also is imposed between consent and operation,⁷⁷ and solicitation of consent during childbirth or abortion is prohibited.⁷⁸

These new rules, however, do not rectify several significant problems. For example, although HEW includes abortion in its description of alternative birth control methods,⁷⁹ it refuses to fund abortions.⁸⁰ Consequently, this

69. *Id.* at 1205. HEW was ordered to advise persons at "the outset and prior to solicitation" of consent that the decision not to be sterilized would not affect federal benefits. *Id.* at 1204-05.

70. 42 C.F.R. § 50.201-04 (1974). These provisions included a "fair explanation" of the procedure, the risks and benefits, and a description of alternative birth control methods. Complying with the court's mandate, HEW required that notice be given that the sterilization decision would not affect any federal benefits. A three day waiting period was imposed between consent and operation, as well as documentation of that consent. *Id.* at §§ 50.202-.203c.

71. Arrastia, *New Regulations for Sterilization*, SEVEN DAYS, Feb. 24, 1978, at 13; Evanoff, *Sterilization Guidelines*, 80 HEALTH PAC. BULL. 19 (1978) [hereinafter cited as Evanoff]; Comment, *Contraceptive Sterilization: The Need for State Regulation*, 6 GOLDEN GATE L. REV. 79 (1978); Comment, *Coerced Sterilization Under Federally Funded Family Planning Programs*, 1976 UTAH L. REV. 589.

72. REPRODUCTIVE FREEDOM PROJECT OF THE AMERICAN CIVIL LIBERTIES UNION, HOSPITAL SURVEY ON STERILIZATION POLICIES 21 (March 1975) [hereinafter cited as ACLU STUDY]. See also HRG STUDY, *supra* note 18, at 4-5.

73. 42 Fed. Reg. 62,718 (1977).

74. 43 Fed. Reg. 52,146 (1978).

75. *Id.* at 52,157 (to be codified in 42 C.F.R. § 50.204 (2), (4), (5)).

76. *Id.* (to be codified in 42 C.F.R. § 50.204(a)(1)).

77. *Id.* at 52,150 (to be codified in 42 C.F.R. § 50.203). Subsection (d) contains two exceptions where consent may be obtained earlier: emergency abdominal surgery (72 hours must pass between consent and surgery) and premature delivery (consent may be given at delivery as long as informed consent was given 30 days before the expected delivery date). The regulations also mandate that the person be informed that sterilization is considered irreversible. *Id.* at 52,157 (to be codified in 42 C.F.R. § 50.204(3)).

78. 43 Fed. Reg. 52,157 (to be codified in 42 C.F.R. § 50.204(e)(1)(ii)).

79. 43 Fed. Reg. 52,168 (1978). It is included in the pamphlet appended to the consent form which is not required to be given to the individual. Information about alternative methods of birth control, as well as other information, must be given orally. There is no requirement that the information be in writing.

80. 39 Fed. Reg. 42,920 (1974). Recently, HEW amended its regulations to provide for federal financial participation in state funding of abortions in limited cases. 43 Fed. Reg. 3,168

alternative is effectively foreclosed to indigent women who then may feel compelled to submit to sterilization. In contrast, HEW reimburses the states for ninety percent of the cost of sterilization because this procedure, unlike abortion, is considered a family planning service.⁸¹

Several critics point out that this refusal to require states to fund abortions presents a real danger that medicaid patients will be subjected to increased pressure to undergo sterilization.⁸² Others report that abortions are being offered in exchange for submitting to sterilization.⁸³ Some critics further maintain that HEW's practice of funding sterilization, an effective but irreversible procedure, and excluding the funding of abortions, a back up service to less effective but reversible birth control, is coercive in and of itself.⁸⁴

The most significant criticism left unanswered by the new regulations is the lack of a strong enforcement provision.⁸⁵ The signed consent form continues to be the sole enforcement mechanism,⁸⁶ and although an unsigned form is tantamount to noncompliance with the regulations, it only results in denial of government funding for that particular procedure.⁸⁷ No sanctions are imposed upon the provider for failure to comply with the regulations.⁸⁸

(1978). In the following situations state funded abortions are allowed: where the life of the mother would be endangered by pregnancy, 42 C.F.R. § 50.304; where the pregnancy would cause severe and long lasting damage to the mother's physical health, 42 C.F.R. § 50.305; and where pregnancy is caused by rape or incest, 42 C.F.R. § 50.306.

81. 39 Fed. Reg. 42,920 (1974). The restrictions on federally funded abortions likewise restrict the practical effect of alternative birth control methods. A woman knows that if she uses a less effective but reversible method and that method fails, she cannot obtain an abortion with federal funds.

82. See ACLU STUDY, *supra* note 72.

83. See note 22 and accompanying text *supra*.

84. See Arrastia, *supra* note 22; Evanoff, *supra* note 71.

85. Federal financial assistance administered by the Public Health Service (PHS) is not available for sterilization procedures unless the consent form appended to the regulations or one approved by HEW is used. 43 Fed. Reg. 52,165 (1978) (to be codified in 42 C.F.R. § 50.209(a)). Documentation includes consent forms and acknowledgement of receipt of hysterectomy information. *Id.* (to be codified in 42 C.F.R. § 50.209(b)). Individual provider reimbursement for sterilization requires compliance with the provisions of 42 C.F.R. § 50.204.

86. Compare 39 Fed. Reg. 4,734(6)(c) (1974) with 43 Fed. Reg. 52,167 (1978). Thus, "enforcement" means a denial of federal reimbursement for the cost of the procedure. Under HEW's "enforcement", the provider could forego compliance and simply not be paid. A teaching hospital might be willing to "pick up the tab" so that residents could get surgical training. See note 23 *supra*.

87. The only monitoring and enforcement provided by the regulations are the requirement that the program or project maintain "sufficient records and documentation" to assure compliance. 43 Fed. Reg. 52,167 (1978) (to be codified in 42 C.F.R. 50,210). HEW intends to monitor and enforce compliance with the regulations "to the best of its ability." 43 Fed. Reg. 52,164 (1978). The present monitoring efforts of APS, HCFA, and PHS will continue and will be supplemented by a program of monitoring by the Inspector General. *Id.*

88. The new regulations do not change the previous enforcement mechanisms. Thus, if the consent form is filled in and signed according to the regulations, there is compliance with the rules and the provider is reimbursed. Noncompliance results in rejection of the claim for pay-

Thus, as indicated in a 1975 study, this minimal enforcement mechanism has little, if any, impact on compliance with sterilization regulations.⁸⁹ For example, from a total of fifty-one hospitals responding to a survey, thirty-six were in complete noncompliance with the regulations.⁹⁰ Even after HEW resurveyed and confirmed these results, however, it failed to take any enforcement action.⁹¹ A more recent study also evidenced this lack of impact.⁹² It found that as of 1977, many hospitals still were not complying with the 1974 regulations.⁹³

Although the adopted regulations do bring some needed changes, their effect is limited because of the lack of a strong enforcement provision.⁹⁴

ment. For example, as late as 1977, Illinois providers were submitting bills for procedures that did not meet the federal requirements of 1974. Variant forms resulted in rejection of the bill. 2 MEDICAID MESSAGE 2 (Feb. 1977). Thus, nonpayment does little to ensure compliance with federal regulations. The imposition of sanctions would provide greater incentive.

89. See ACLU STUDY, *supra* note 72. Of the 154 hospitals surveyed, two-thirds failed to respond. *Id.* at 5.

90. *Id.* at 20. Still another twelve failed to be in complete compliance. *Id.* at 21.

91. CENTER FOR DISEASE CONTROL, FAMILY PLANNING EVALUATION DIVISION, AN ASSESSMENT OF POLICY COMPLIANCE WITH FEDERAL CONTROL OF STERILIZATION (1975), cited in Statement of Pamela Horowitz, Legislative Counsel, ACLU, on Proposed Restrictions Applicable to Sterilizations Funded by the Department of HEW (Jan. 17, 1978) (Attachment A). Another example of failure to take enforcement action is the 1975 Sterilization Review of the Illinois Department of Public Aid by HEW. Although the 72-hour waiting period was not met and the consent form lacked vital information (such as the notice requirements as to federal benefits and whether the patient was informed of the irreversibility of sterilization), payment was allowed. Report from HEW on Illinois (April 21, 1975) (obtained pursuant to FOIA request).

92. Letter from Nancy Stearns, Staff Attorney of the Center for Constitutional Rights, to Joseph A. Califano (Dec. 27, 1977) (Reprint of survey available from CCR, 853 Broadway, New York, N.Y. 10003) [hereinafter cited as Stearns].

93. In 33% of the teaching hospitals responding, the hospitals were obtaining consent during labor and 58% were doing likewise at the time of admission for an abortion. *Id.* at 4. An additional 30% did not indicate on the consent form that the sterilization decision could not affect federal benefits. Stearns, *supra* note 92, at 3.

A survey of Chicago-Cook County area hospitals conducted in October, 1978, also found that 22 out of 32 hospitals were in non-compliance with the 1974 HEW regulations. M. Keefe & M. Kelly, Legal Assistance Foundation Sponsored Survey of Chicago Hospitals (unpublished study available, 343 S. Dearborn, Chicago, Illinois 60604). From January through June of 1978, 2,261 women in Illinois receiving medical assistance were sterilized, and 66.5% of these operations took place in Cook County. Letter from S. Miller, Administrator of the Illinois Medical Assistance Program, to Ms. Hatchett & Ms. Goodman (Aug. 30, 1978). A total of 14,989 Illinois women receiving such assistance were sterilized from July of 1975 to January of 1978. HEW, Monthly Statistical Report on Medical Care Part IV, National Center for Social Statistics [hereinafter cited as HEW Report]. One hundred and ten of these sterilizations were performed on women less than 21 years of age, violating the moratorium imposed by the Secretary of HEW on July 27, 1973, 38 Fed. Reg. 20,930 (1973). This moratorium remained in effect until the 1978 regulations were adopted. 42 Fed. Reg. 62,718, 62,719 (1977). Ten of the Illinois sterilizations were on girls under 18 years of age, in direct violation of the 1974 regulations. 39 Fed. Reg. 4732 (1974).

94. Noncompliance with the federal regulations merely results in nonpayment from HEW for the procedure. 43 Fed. Reg. 52,163 (1978) (to be codified in 42 C.F.R. § 50.209(b)). See notes 23 and 86 *supra*.

Moreover, these guidelines only apply to federally funded sterilizations. Therefore, state regulations are necessary to ensure that all sterilization decisions are both informed and voluntary.

Judicial Response to Sterilization Abuse

Not only are the federal regulations inadequate, but civil rights actions also have proven to be unsuccessful in redressing the wrong perpetrated by sterilization abuse. *Walker v. Pierce*⁹⁵ amply illustrates the difficulties encountered in such actions. Two black women receiving medical assistance⁹⁶ under the medicaid program sued an obstetrician in *Walker*⁹⁷ for sterilizing them or threatening to do so solely on account of their race and number of children.⁹⁸ One plaintiff refused sterilization after delivery of her third child. Upon notice of her refusal, the doctor ordered her discharge from the hospital.⁹⁹ The other plaintiff, while pregnant with her fourth child, was threatened by the doctor with termination of welfare assistance and medical care if she did not consent to sterilization.¹⁰⁰

In discussing *Walker*, one commentator stated that the three physicians practicing in that county agreed among themselves that maternity services should be provided to a mother of a third illegitimate child only upon the mother's consent to sterilization.¹⁰¹ Dr. Pierce, the doctor involved in *Walker*, was the *only obstetrician* in the county.¹⁰² The court of appeals¹⁰³

training. See note 23 *supra*.

95. 560 F.2d 609 (4th Cir. 1977). This civil rights action was brought under 28 U.S.C. § 1983.

96. The Medicaid program provides federal financial participation in the state's public assistance of Medicare.

97. *Walker v. Pierce*, 560 F.2d 609, 610 (4th Cir. 1977). The other defendants were the chairperson and the administrator of the hospital, the director of the County Department of Social Services of South Carolina and the hospital. They were charged with conspiring or acting in concert with the obstetrician. *Id.*

98. *Id.* at 610.

99. *Id.* at 612. The fourth circuit reversed a \$5.00 nominal damages jury award to this plaintiff on the ground that the requisite state action was lacking. *Id.* at 613.

100. *Id.* at 611. The doctor had written to the Department of Social Services asking that a caseworker speak to the plaintiff about sterilization. There was conflicting evidence about whether the caseworker offered to find her another doctor or said there was nothing that he could do. Nevertheless, she consented to sterilization. She testified that she did not protest because she felt that it would have been futile. *Id.*

101. See LITTLEWOOD, *supra* note 1, at 109. It is not surprising then that when one of the plaintiffs in *Walker* called another doctor, he was not taking new patients. *Walker v. Pierce*, 560 F.2d 609, 611 (4th Cir. 1977).

102. *Id.* Justice J. Butzner, dissenting in part, quotes one witness' testimony as to Dr. Pierce's introduction before performing an obstetrical exam:

upheld his policy, requiring sterilization as a condition to medical services for any woman pregnant with a third child who was either receiving assistance or unable to pay her own bill. In so doing, it stated that:

We perceive no reason why Dr. Pierce could not establish and pursue the policy . . . Nor are we cited to judicial precedent or statute inhibiting this personal economic philosophy. Particularly is this so when all persons coming to him as patients are seasonably made fully aware of his *professional* attitude toward the increase in offspring and his determination to see it prevail. At no time is he shown to have forced his view upon any mother.¹⁰⁴

The fourth circuit's sanction of Dr. Pierce's "personal economic philosophy" also tacitly gave approval to the economic incentive involved in his sterilization policy. The court noted that within one and one-half years, Dr. Pierce had been reimbursed \$60,000 by the government for medicaid "services."¹⁰⁵ Out of forty medicaid deliveries by Dr. Pierce, seventeen sterilizations were performed and at least sixteen of these were performed on black women.¹⁰⁶ Yet, the court ultimately found that there was no constitutional or statutory violation in the practice of conditioning necessary medical services for medicaid patients upon their consent to sterilization.¹⁰⁷

He came in and he hadn't examined me or anything. I was laying on the table. And, he said, "listen here young lady." He said, "This is my tax money paying for something like this." He said, "I am tired of people going around here having babies and my tax money paying for it." He said, "So, if you don't want this done, you go and find yourself another doctor."

Id. at 614. It is significant that Dr. Pierce received \$60,000 in Medicaid fees for a one and one-half year period. *Id.* at 612. Perhaps his tax concern was not the motivating factor in conditioning obstetrical care for Medicaid patients upon acceptance of sterilization.

103. The lower court entered judgment on a jury verdict for \$5.00 and denied declaratory or injunctive relief regarding Dr. Pierce's alleged sterilization or threat of sterilization of the plaintiffs on account of their race and number of children.

104. *Walker v. Pierce*, 560 F.2d 609, 613 (4th Cir. 1977).

105. *Id.* at 612.

106. *Id.* at 612 n.4.

107. *Id.* at 613. The court found that Dr. Pierce was not acting under color of state law within the meaning of 42 U.S.C. § 1983. The dissent distinguished Dr. Pierce's role as a physician treating isolated patients and his role as a participant in the fiscal and administrative aspects of the Medicaid program. A sufficient nexus between the state and the challenged action of the defendant was found. The court applied the principal that action under color of law may be found when the state is involved in the activity or the private actor assumes a state or public function. *Id.* at 614-15 (citations omitted).

The dissenting justice found that Dr. Pierce's policy of sterilization for economic reasons established that he was acting under color of state law. Dr. Pierce's activity consisted of granting or denying Medicaid benefits for fiscal reasons unrelated to health. Since the state is responsible for ascertaining entitlement for Medicaid benefits, the dissent reasoned that Dr. Pierce assumed a state function. An additional factor was that South Carolina did not contract with

Surely, however, a sterilization decision based upon such a condition is not voluntary within the meaning of Congress' statutory mandate that federally funded family planning services be requested voluntarily.¹⁰⁸

The decision of another civil rights action, *Madrigal v. Quilligan*,¹⁰⁹ also appears to have condoned sterilization abuse. In *Madrigal*, ten Mexican women brought a § 1983¹¹⁰ civil rights action against the University of Southern California (USC-LA) County General Hospital and its director of Obstetrics and Gynecology for sterilizing them without first obtaining their informed consent.¹¹¹ The court, acting as trier of fact, characterized the suit as resulting from a breakdown in communications which was largely due to the plaintiffs' limited ability to understand and speak English.¹¹² Although the court noted that most members of the staff at the Medical Center were familiar with the Spanish language and that an interpreter was available, the staff was excused because "even with these precautions misunderstandings are bound to happen."¹¹³

Additionally, the *Madrigal* court remarked that the Mexican culture defined a woman's worth largely in terms of her ability to produce children.¹¹⁴ While recognizing that this factor rendered the sterilization decision more difficult and traumatic and thus necessitated greater explanation, advice, and care when interpreting the patient's consent, the court pardoned the staff of this "busy metropolitan hospital" for not making such an effort.¹¹⁵ Accepting the doctors' testimony that they acted in good faith in

physicians directly but allowed doctors to accept or reject the Medicaid patient seeking their services. Since the state did not know of the relationship until a bill was presented, the state delegated much of its administrative responsibility for the operation of Medicaid to the doctors. Therefore, the dissent concluded that Dr. Pierce assumed a state administrative function by conditioning medical benefits on requirements not related to health, while publicly representing himself as a qualified Medicaid practitioner. Finally, the justice noted that Dr. Pierce was free to decline to treat any Medicaid patient but chose not to do so and was paid. *Id.* at 614-15 (Butzner, J., dissenting).

108. The court's decision does not reveal whether this argument was presented. Congress, however, included in every section mentioning family planning a requirement that such services be voluntarily requested. 42 U.S.C. §§ 302a-5, 602(a)(15), 708(s)(1396d)(a)(4).

109. No. CV 75-2057-JWC (D. Cal., filed June 30, 1978).

110. 42 U.S.C. § 1983 recognizes a cause of action for violation of civil rights under color of state law.

111. *Madrigal v. Quilligan*, No. CV 75-2057-JWC, slip op. at 8 (D. Cal., filed June 30, 1978). Two of the plaintiffs were dismissed. Of the remaining eight women, six consented to sterilization while they were in labor, one woman's husband consented on behalf of his wife, and one woman never signed a consent form.

112. *Id.* slip op. at 6.

113. *Id.* The court also found that the cultural background of the plaintiffs contributed to the problem "in a subtle but very significant way." *Id.* One predominant trait of the Mexican culture is extreme dependence upon the family. In addition, the status of the woman in the family is determined by her ability to reproduce, rendering the sterilization decision more difficult. *Id.* slip op. at 7.

114. *Id.*

115. *Id.*

obtaining and believing the consent, the court found that this good faith belief absolved them from liability.¹¹⁶

The court also noted that even if it were shown that the plaintiffs did not actually intend to consent, a negligent interpretation of the plaintiffs' communications which indicated consent to sterilization would shield the doctors from liability.¹¹⁷ The court reasoned that liability in this situation could be predicated only upon conduct which was malicious or constituted reckless disregard of the patient's constitutional rights.¹¹⁸

The results obtained in *Madrigal* and *Pierce* illustrate that sometimes courts are reluctant to redress the wrong perpetrated by sterilization abuse. Moreover, civil rights actions are remedial in nature and thus do nothing to actually prevent abuses. The only present alternative, therefore, seems to be the future passage of regulations in this area.

116. *Id.* slip op. at 4. Although the court found requisite state action, this good faith belief entitled the doctors to immunity under the qualified immunity doctrine enunciated in *Downs v. Sawtelle*, 574 F.2d 1, 11-12 (1st Cir. 1978). There, a deaf woman was sterilized after she explicitly refused to consent. On remand, the jury found for the doctor. The first circuit recognized that the doctor involved was entitled to qualified immunity, dependent on the kind of conduct involved, which was a question for the jury. *Id.* at 11. Qualified immunity shields certain state officers from damage liability for official actions taken in good faith. *Id.*

117. *Madrigal v. Quilligan*, No. CV 75-2057-JWC, slip op. at 6 (D. Cal., filed June 30, 1978).

118. *Id.* Relying again on *Downs*, the *Madrigal* court noted that the defendant doctor would have been acting maliciously if he or she had ignored the plaintiff's desires in determining that sterilization was necessary for their own good or the good of society. Liability also would have existed if the doctor attempted to take advantage of the plaintiff's mental and communication limitations to unduly influence their decision. *Id.*

The *Downs* court, however, defined malicious as "callousness" or wanton neglect and reckless indifference to the rights of individual citizens. Indeed, it specifically noted that the determination of whether the conduct at issue was wanton or reckless depended in part on the context in which it occurred, including the inability of the victim to protect herself. Thus, the *Downs* court evaluated the doctor's conduct and recognized the "extraordinary degree of helplessness of the plaintiff." *Downs v. Sawtelle*, 574 F.2d 1, 12 (1978).

The plaintiff in *Downs* was deaf and had a limited ability to communicate. The plaintiffs in *Madrigal* also had a limited ability to communicate due to a language barrier. It seems that if the *Madrigal* court had considered the inability of these plaintiffs to protect themselves in a foreign environment where a foreign language was spoken, the result may have been different. The *Madrigal* court also refused to consider the doctor's conduct in the context in which it occurred. Although most of these women were in labor when their consent was obtained, the court characterized the notion that a woman would not be able to give informed consent while in labor as a "statement [which] completely defies common sense." *Madrigal v. Quilligan*, No. CV 75-2057-JWC, slip op. at 18 (D. Cal., filed June 30, 1978). The court accepted as more credible the testimony of the defendant doctors that informed consent depended on many facts, and a decision about whether consent was informed was a judgment best made by "someone present at the moment the decision is made." *Id.* slip op. at 19. The court also cited evidence that the attending physician was "probably" in the best position to make a judgment since "he would be acutely aware of the necessity of having the patient's consent." *Id.* This is contrary to California's precedent regarding informed consent. See notes 178-187 and accompanying text *infra*.

A PROPOSED REGULATORY SCHEME TO ENSURE AN
INFORMED AND VOLUNTARY STERILIZATION DECISION

Given the evidence of past abuse and lax enforcement of existing HEW regulations, it is submitted that state legislation regulating informed consent to sterilization is necessary. The suggested scheme¹¹⁹ provides for uniform application, disclosure of information, and enforcement. These proposals will be discussed further in the following sections.

Sterilization Defined

State regulations should ensure that sterilization be both available and chosen voluntarily. To be most effective, the regulations should apply to all sterilizations and eliminate the distinction between therapeutic and non-therapeutic sterilizations. Since any sterilization can be defined medically as therapeutic, this demarcation easily could be abused.¹²⁰ Furthermore, there is no reason why a "therapeutic" sterilization should not also be a voluntary and informed one. As the court in *Relf v. Weinberger*¹²¹ noted when abolishing the therapeutic distinction in federally financed sterilizations, Congress contemplated no such distinction when it established the voluntary requirement.¹²²

Hysterectomy is another procedure which easily can be defined as medically therapeutic. Although the number of these operations is rapidly in-

119. See the appendix following this comment.

120. HEW previously regulated only non-therapeutic sterilizations. Therapeutic sterilization, as defined by the 1974 HEW regulations was a necessary part of the treatment of an existing illness or injury or medically indicated as an accompaniment of an operation on the female genito-urinary tract. . . . 39 Fed. Reg. 4,732 (1974) (to be codified in 42 C.F.R. 50.202(b)). This definition excluded post caesarean sterilizations from informed consent regulation. This type sterilization is, however, a major source of abuse. See HRG STUDY, *supra* note 18, at 4. The "medical indication" for sterilization due to caesarean section is discredited in the literature. *Id.* at 10. Its complication rate is very high: 51.1% if performed with a tubal ligation and 71.4% if performed with a hysterectomy. See Tappan, *supra* note 21, at 155. Thus, the distinction between therapeutic and non-therapeutic serves no purpose for informed consent. Only emergency sterilization for uterine rupture and other immediate life threatening situations should be exempt from the regulations. Indeed, one writer notes, "[a] growing tendency to broaden the medical indications is evident so that, in some instances, these may be merely a camouflage for socioeconomic reasons". Adams, *Female Sterilizations*, 89 AM. J. OBSTETS. & GYN. 395 (1964) [hereinafter cited as Adams]. In an apparent response to this criticism, HEW's 1978 regulations define sterilization as any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. 43 Fed. Reg. 52,149 (1978) (to be codified in 42 C.F.R. § 50.202). The purpose test creates a loophole because practitioners may avoid the restrictions of the regulations by articulating a different purpose. HEW responded to the alternative "has the effect of producing sterility" test by characterizing it as too broad. 43 Fed. Reg. 52,149 (1978) (to be codified in 42 C.F.R. § 50.202).

121. 372 F. Supp. 1196 (D.D.C. 1974).

122. The *Relf* court contemplated that all sterilizations, except emergency cases, would need a "voluntary, knowing and uncoerced consent." 372 F. Supp. 1196, 1201 (D.D.C. 1974).

creasing,¹²³ reports indicate that one-third to two-thirds of them are unnecessary.¹²⁴ Since a hysterectomy can be performed for other reasons,¹²⁵ it may be used as a covert method of sterilization.¹²⁶ Moreover, hysterectomy has a greater risk of complication than other elective surgical sterilization methods.¹²⁷ Accordingly, it should not be looked upon as an appropriate elective sterilization procedure and should be eliminated from the statutory definition of sterilization in a model statute.¹²⁸ Such a statute also should contain a prohibition against the use of hysterectomy as an accepted

123. During a two year period from 1968 to 1970, there was a 742% increase in hysterectomy operations at the Women's Hospital of L.A. County Medical Center. See HRG STUDY, *supra* note 18, at 1. In Illinois, at least 13,228 hysterectomies were performed upon women receiving medical assistance during a three-year period. Letter from A. Steiz, Illinois Department of Public Aid, to Mary Kelly, March 29, 1979.

124. Brody, *Incompetent Surgery Is Found Not Isolated*, N.Y. Times, Jan. 27, 1976, at 24, col. 1. In Saskatchewan, the Provincial College of Physicians and Surgeons organized a committee of medical and nonmedical personnel which published medical criteria for a hysterectomy. Sterilization was not considered a medical indication of hysterectomy. See Dyck, Murphy, Road, Boyd, Osborne, Vlieger, Korchinski, Ripley, Bromley & Innes, *Effect of Surveillance on the Number of Hysterectomies in the Province of Saskatchewan*, 296 N. ENG. J. MED. 1326, 1328 (1977) [hereinafter cited as Dyck]. The committee found the number of unnecessary hysterectomies performed in seven major provincial hospitals ranged from a high of 59% to a low of 17%. *Id.* at 1327. Through committee action, these numbers decreased to a range of 16% to 2%. *Id.* See also Affidavit of Dr. Helen Rodriguez, Complaint in Intervention, Exhibit D at 6, California Medical Ass'n v. Lackner, No. 268099 (Cal. Super. Ct. April 28, 1978) [hereinafter cited as Rodriguez Affidavit]. It generally is agreed that the number of unnecessary hysterectomies is due in large part to its use on poor women as a training procedure for residents. See HRG STUDY, *supra* note 18, at 2-3.

125. Dyck, *supra* note 124, at 1326-27.

126. HRG STUDY, *supra* note 18, at 32. The incentive also might be an economic one. As Dr. Lewis states:

It seems to me inevitable . . . that in any occupation where considerable income is available on the basis of events called operations, a small percentage of people can well identify this as a marvelous income-producing device. . . .

Lavin & Busek, HOSPITAL PHYSICIAN 35 (Feb. 1973), cited in HRG STUDY, *supra* note 18, at 19 (emphasis added).

127. *Fit To Be Tied*, *supra* note 4, at 2.

128. HEW's proposed rules would have eliminated hysterectomy as an acceptable family planning method. If it is performed for other reasons, however, it could be funded if the procedure met the criteria of other provisions authorizing funding for medical assistance. 42 Fed. Reg. 62,726-27 (1977).

The current regulations continue to disallow federal funding of hysterectomies solely to render an individual permanently incapable of reproducing. 43 Fed. Reg. 52,162 (1978) (to be codified in 42 C.F.R. § 50.207). Any hysterectomy performed for other reasons may be funded if the patient is informed orally and in writing that the procedure will render her permanently incapable of reproducing. In addition, the patient must sign a document acknowledging receipt of the information. *Id.* Both the consent form and the signed receipt are necessary for federal reimbursement. 43 Fed. Reg. 52,163 (1978) (to be codified in 42 C.F.R. § 50.209(b)).

family planning method.¹²⁹ A hysterectomy should be performed only when it is medically necessary and should not be used for contraceptive purposes. If it is determined that a woman needs a hysterectomy for medical reasons, it should be required by statute that she be informed she is entitled to a second opinion from another doctor.¹³⁰ Such provisions would help reduce the number of hysterectomies which are of questionable necessity.

Information Necessary to the Sterilization Decision

Restrictions on access to or information about alternative birth control methods necessarily increase the potential for sterilization abuse. If temporary forms of birth control are not explained, a person who presently does not want children may feel compelled to "choose" sterilization rather than risk a pregnancy. As a consequence, it is imperative that alternatives are explained and made available. New York City¹³¹ and California regulations¹³² serve as an instructive model because they require an explanation of the advantages and disadvantages of each alternative birth control method.

This requirement is an important one. The effective evaluation and selection of a birth control method requires more than mere explanation of the various techniques. For example, convenience makes the "pill" the most desirable method and the diaphragm the least until the many serious and life threatening risks associated with the "pill" are revealed.¹³³ Similarly, sterilization may be the most desirable because of its effectiveness. Its permanence and irreversibility, however, may make it less desirable than a more temporary method, especially if abortion is available as a backup service in the event a temporary method fails.¹³⁴

Patients should be told that sterilization is irreversible and that this means he or she will *never* be able to have children again.¹³⁵ This would insure

129. Hysterectomy has a complication rate 10 to 20 times greater than that of a tubal sterilization procedure. Hibbard, *Sexual Sterilization by Elective Hysterectomy*, 112 AM. J. OBSTETS. & GYN. 1076, 1081 (1972). Thus, other methods are preferred.

130. California legislation provides that before *any* sterilization procedure is performed, the patient must be informed of the right to a second opinion. CAL. ADM. CODE tit. 22, § 70707.4(2) (1977).

131. N.Y. CITY ADM. CODE ch. 22, § C22-5.0(2) (1977).

132. CAL. ADM. CODE tit. 22, § 70707.3 (1977).

133. PHYSICIAN'S DESK REFERENCE 1152-54 (31st ed. 1977).

134. The type of counseling a patient receives determines her decision. Dr. Quilligan, chairperson of the Obstetrics and Gynecology Department at U.S.C.-L.A. County Medical Center told a reporter that they refused many patients requesting sterilization. When the reporter asked how that was managed, he responded "[w]ell let's just say we counsel them so they don't want it." Dreifus, *supra* note 18, at 18.

135. HEW has taken an equivocal stance on the permanence of sterilization. This is reflected in its requirements that patients be told sterilization "is considered" to be irreversible. 43 Fed. Reg. 52,153 (1978) (to be codified in 42 C.F.R. § 50.203(a)). *But see* note 2 *supra*, which states that tubal ligations have been reversed in rare instances. One physician performing such procedures, however, noted that sterilization "should be approached with the firm expectation of

that persons seeking sterilization are not misled into thinking their tubes can be "untied" at some time in the future.¹³⁶ Given the amount of misinformation concerning the permanence of sterilization, it is important that those describing the procedure be required to give correct information.¹³⁷ There is no room for "fudging." Since sterilization is the permanent relinquishment of the fundamental right to procreate,¹³⁸ all ambiguities as to its process and effects should be resolved.

A model statute, therefore, should incorporate this information regarding the irreversibility of sterilization. In addition, the advantages and disadvantages, including the known and suspected side effects of each birth control method, should be explained orally and in writing in a clear and simple manner. Similarly, the alternative methods of sterilization and their attendant risks and benefits, including known and suspected long term side effects, should be revealed.

An ideal provision would be one which is modeled after the California regulation.¹³⁹ It would require an explanation of the risks and benefits of the different types of sterilization procedures.¹⁴⁰ This provision also would

having no more babies." Clark & Shapiro, *Undoing Sterilization*, NEWSWEEK, July 10, 1978, at 77.

136. Dreifus, *supra* note 18, at 16. Dr. Janet Winikoff, a second year resident at Cook County Hospital in Chicago, Illinois, testified that a patient came to the clinic to get her tubes untied as she had been told she could before surgery. Dr. Janet Winikoff, Testimony to the Department of Health, Education & Welfare on Sterilization Regulation (February 1, 1978) [hereinafter cited as Testimony of Dr. Janet Winikoff to HEW]. Dr. Winikoff is a resident in internal medicine and this was the second patient in a year to make this request. Since Dr. Winikoff rarely deals with gynecological problems in internal medicine, she presumed that numerically the two women represented the "tip of the iceberg." *Id.*

137. *Id.* See generally Dreifus, *supra* note 18. Women are often convinced to undergo sterilization with a soft-sell pitch. Doctors attempt to minimize the dangers involved in sterilization by "describing laparoscopies as bandaid surgery and calling tubal ligations a stitch." *Fit To Be Tied*, *supra* note 4, at 4. For example, laparoscopic electrocoagulation of the fallopian tubes or diathermy, which is the newest and one of the most popular sterilization techniques, causes a syndrome of delayed complications. These include dysmenorrhea (painful menstruation), menorrhagia (excessive menstrual bleeding), and dyspareuria (painful intercourse), and are frequently severe enough to require a hysterectomy. *Late Effects of Sterilization Feared*, MED. WORLD NEWS, May 31, 1977, at 30. Another example is abdominal tubal ligation. This is the most common method of postpartum sterilization because it is the easiest method to perform at the time of childbirth. See *Fit To Be Tied*, *supra* note 4, at 2. This is major surgery and the mortality rate is 25 per 100,000 women. *Id.* See also Tappan, *supra* note 21, at 154-55 for a discussion of the side effects of tubal ligation. Out of 404 patients receiving tubal ligation, 40.7% had a heavier menstrual flow and 20.8% had a more painful menses. These tubal ligations were performed by the more traditional methods of laparoscopy and laporotomy. *Id.*

138. See notes 47-52 and accompanying text *supra*.

139. CAL. ADM. CODE tit. 22, §§ 70707.3-.4 (1977).

140. An example of an inadequate provision is HEW's proposed regulations which offer only the advantages and benefits of sterilization. 43 Fed. Reg. 52,157 (1978) (to be codified in 42 C.F.R. § 50.203). Rather than indicating the long term side effects of sterilization, these regulations disclose only the disadvantages and immediate risks associated with the specific procedure to be performed.

specify that the patient receive the following information, orally and in writing, about the various sterilization procedures: 1) the approximate length of stay and recovery; 2) whether the procedure is new or experimental; 3) its cost, and 4) its confirmed and suspected long term consequences.¹⁴¹ In addition, the patient would be given an opportunity to ask questions. Given this data, a person can participate more fully in the sterilization decision.

To further ensure that a patient voluntarily consents to sterilization, the person must be informed that a decision not to be sterilized will not affect receipt of federal benefits or future medical services.¹⁴² In addition, persons must be told that consent to sterilization can be withdrawn anytime prior to surgery.¹⁴³ These additional reassurances are imperative in view of the number of persons who have submitted to sterilization thinking it was mandatory. This misconception existed even though the 1974 HEW regulations required that patients be told orally and in writing that their sterilization decision would not affect benefits.¹⁴⁴ This misconception might be attributed in part to the complex sentence structure and use of double negatives in the written notice.¹⁴⁵

The linguistic complexity of the HEW notice defeats its educational purpose and thus tends to confuse and intimidate the patient. If the purpose of the notice is to inform patients that important benefits will not be lost, then this reassurance must be understandable. Ideally, the complex provision could be replaced with a more simple and direct statement, such as:

IF YOU DECIDE YOU DO NOT WANT TO BE STERILIZED, YOU
WILL CONTINUE TO RECEIVE ALL BENEFITS SUCH AS WEL-
FARE, MEDICAID AND DISABILITY OR MEDICAL SERVICES.
YOUR DECISION WILL NOT CAUSE YOU TO LOSE ANY BENE-
FITS OR SERVICES. YOU CAN CHANGE YOUR MIND AT ANY
TIME BEFORE THE OPERATION.

An additional provision prohibiting the delaying or withholding of medical services while a person is considering sterilization eliminates the potential for "subtle manipulation."¹⁴⁶

141. See generally CAL. ADM. CODE tit. 22, §§ 70707.3-.4 (1977).

142. This notice is provided for in HEW's consent form and must be given orally before the informed consent process begins. 43 Fed. Reg. 52,157 (1978) (to be codified in 42 C.F.R. § 50.204(a)). See also CAL. ADM. CODE tit. 22, § 70707.6(b)(1) (1977) (provides for warning in consent form); N.Y. CITY ADM. CODE ch. 22, § C22-5.0(5) (1977) (provides for an oral warning).

143. CAL. ADM. CODE tit. 22, § 70707.6(b)(1) (1977) (provided for in the consent document); New York City Health and Hospitals Corporation Guidelines for Female Elective Sterilization (15) (November 1, 1975) provides for this orally and in writing.

144. Over 3,000 Indian women were sterilized in 1976. See note 13 and accompanying text *supra*.

145. HEW requires the following notice: "NOTICE: your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects." 43 Fed. Reg. 52,160 (1978).

146. The New York City Health and Hospitals Corporation guidelines for Female Elective Sterilization (15) (November 1, 1975).

The potential for manipulation also exists if the patient speaks a language different from the counselor's or that utilized in the consent form or informational booklet.¹⁴⁷ Thus, a model statute should require that all information be communicated to the patient in his or her primary language. This requirement prevents the miscommunication of necessary information due to a language barrier.

Required Waiting Period

It also is important that the patient be given time to consider this information in a non-hospital atmosphere. Often the hospital environment itself is a frightening and coercive experience.¹⁴⁸ A waiting period between the informed consent process and the actual operation would mitigate these intimidating factors and would allow the patient adequate time to consider options and communicate with others about the decision.

A thirty day waiting period, such as that required by the HEW¹⁴⁹ and New York City legislation,¹⁵⁰ also would ensure that ample time is allowed for withdrawal of consent solicited during labor, immediately post partum, or before or after an abortion. Since these are the times when women are most susceptible to sterilization abuse,¹⁵¹ the regulation should also include an explicit prohibition against solicitation of consent during these periods. Any

147. See *Madrigal v. Quilligan*, No. CV 75-2057-JWC (D. Cal., filed June 30, 1978). HEW's proposed rules only required that the consent form be in the patient's primary language, and if this could not be done, an interpreter would be provided for assistance. 42 Fed. Reg. 62,721 (1977). The adopted 1978 rules require an interpreter only if the consent form is not in a language the patient understands. 43 Fed. Reg. 52,169 (1978). The New York City Health and Hospitals Corporation guidelines for Female Elective Sterilization (8) (November 1, 1975) provide that consent forms and informational material must be available in at least Spanish, French, Chinese, Yiddish, and English. If there is no interpreter available, the patient must be referred to another municipal hospital where one is present.

148. See Rosenfeld's Affidavit, *supra* note 18, at 3, where Dr. Rosenfeld reports that some physicians use their position of authority to induce consent. To support this theory, he cited the following argument made by Les Payne that appeared in *NEWSDAY*, January 2-3, 1974.

It's very easy to influence patients when you're wearing the white coat, especially when they speak no English or are uneducated, the acting director said. They will do what you want, particularly if you suggest to them that to do otherwise would be a jeopardy to their health. You can twist the truth to suit your own needs. And that's what residents in training frequently do.

Rosenfeld's Affidavit, *supra* note 18, at 3.

149. 43 Fed. Reg. 52,150 (1978) (to be codified in 42 CFR § 50.203).

150. N.Y. CITY ADM. CODE ch. 22, § C22-4.0 (1977). California provides for a 14-day wait. CAL. ADM. CODE tit. 22, § 70707.5(3) (1977). It also requires that the patient request the surgery "without fraud, duress or undue influence." *Id.* at § 70707.3(c).

151. As one resident noted, approaching a woman for sterilization during labor is expedient, "although it's like asking a drowning person, do they want to get out of the water." Dreifus, *supra* note 18, at 17. This is also true of the postpartum and abortion periods. Stearns, *supra* note 92, at 3-4. A study analyzing various other studies noted that "[P]atients who are pressured to be sterilized have shown poor adjustment." Schwyhart & Kutner, *A Reanalysis of Female Reactions to Contraceptive Sterilization*, 156 J. NERVOUS & MENTAL DISEASE 354, 361 (1973).

consent obtained during these times necessarily implies coercion. As previously noted, a recent survey revealed that over one-half of the responding teaching hospitals obtained consent to sterilization when women were most vulnerable to such abuse. The thirty day waiting period merely prevents sterilization immediately after obtaining consent during labor. Thus, the wait does not cause hardship or inconvenience. It does not preclude sterilization at the time of delivery, if this is desired. It simply requires that informed consent be obtained thirty days before delivery.¹⁵² In addition, a model statute should follow New York's¹⁵³ example and not allow a waiver of the waiting period. The underlying principle should be that if one is to err at all, it should be on the side of caution.¹⁵⁴

Minimum Age

Extreme caution should be exercised in the sterilization of minors.¹⁵⁵ Pursuant to Judge Gesell's order in *Relf v. Weinberger*,¹⁵⁶ HEW imposed a moratorium on the use of federal funds to sterilize minors. HEW's present rules continue this ban.¹⁵⁷ Since it is questionable whether there is an ac-

152. While HEW's proposed rules provided for a thirty day waiting period, HEW simultaneously proffered a seemingly logical criticism to the suggested waiting period. The Department stated that a waiting period longer than the presently required 72 hours results in a second hospitalization with the burden of increased cost. 42 Fed. Reg. 62,722 (1977). This criticism is not very persuasive, since one of the most popular types of sterilization, laparoscopy, can be performed on an out-patient basis. *Late Effects of Sterilization Feared*, MED. WORLD NEWS, May 31, 1977 at 30.

Therefore, a second hospitalization would not be required for the sterilization procedure, whether the waiting period is thirty days or 72 hours. Moreover, the thirty-day wait does not preclude sterilization at delivery; it simply requires a woman to sign the consent form thirty days before delivery. Thus, the thirty-day wait ensures that women will not be approached for consent *during* delivery, but it does not prevent sterilizations at the time of delivery. HEW's present rules provide for a thirty-day wait except in the case of premature delivery and emergency abdominal surgery. In these instances, the waiting period is 72 hours. 43 Fed. Reg. 52,150 (1978) (to be codified in 42 C.F.R. § 50.203).

153. The New York City Health and Hospital Corporation Guidelines for Female Elective Sterilization do not provide for waiver. The City laws, however, do provide for waiver if delivery is sooner than expected or the patient is admitted for emergency abdominal surgery and has already signed the consent form. N.Y. CITY ADM. CODE ch. 22, § 22-4.0 (2) (1977).

154. Adams, *supra* note 120, at 401, notes that 36% of the group studied who did not wait the thirty day period were unhappy with the procedure as compared to 16% who did wait thirty days and were regretful.

155. The Hospital Discharge Survey estimates that 5,700 females under 15 years of age have been surgically sterilized. Letter from R. Weinzimer, Public Information Specialist, National Center for Health Statistics, to Mary Keefe (March 19, 1979).

156. 372 F. Supp. 1196, 1204-05 (D.D.C. 1974). The court noted that "[m]inors . . . are undoubtedly sufficiently aware of the relevant considerations to use temporary contraceptives that intrude far less on fundamental rights . . . [T]he Court cannot find that Congress deemed such children capable of voluntarily consenting to an irreversible operation involving the basic human right to procreate." *Id.* at 1202.

157. 43 Fed. Reg. 52,151 (1978) (to be codified in 42 C.F.R. § 50.203(a)).

tual need to make sterilization available to anyone under the age of twenty-one,¹⁵⁸ any hardship caused by a minimum age requirement is outweighed by the adverse consequences that could occur without it.¹⁵⁹ Sterilization should be available to those under twenty-one only if its non-performance would be life-threatening. Persons under twenty-one lack the maturity to make such a permanent decision and thus are more prone to regret it.¹⁶⁰ If non-performance of sterilization is deemed life-threatening, a second medical opinion should be required. Even with this provision, however, the potential for abuse exists.¹⁶¹ Therefore, strong enforcement measures are necessary.

Enforcement

Since any regulation is ineffective unless enforced, state legislation should contain enforcement and monitoring provisions. A stronger mechanism than the HEW consent form, which recites that the requisite information was conveyed, is necessary.¹⁶² It does not follow from the mere recitation of compliance that there is in fact compliance with the regulations. Signatures on consent forms, while necessary, are not sufficient to ensure that consent is voluntary and informed. It is not uncommon for consent to be obtained in a perfunctory manner. Indeed, consent forms often are treated by hospital personnel as yet another piece of "bureaucratic tedium" to be disposed of as quickly as possible.¹⁶³ Requiring a witness to be present during the informational session would act as a deterrence to such an attitude and resulting practice.¹⁶⁴

158. See note 156 *supra*. It seems unlikely that most persons under twenty-one would have completed their families. As the *Relf* court noted, minors may be aware of relevant considerations to use temporary contraceptives which intrude less on fundamental rights, but such "children" may not be capable of consenting to an irreversible operation involving the "basic human right to procreate." 372 F. Supp. 1196, 1204-5 (D.D.C. 1974).

159. Of the mothers dissatisfied with the sterilization, 54% were twenty-five years or younger and 81.1% were under thirty. Adams, *supra* note 120, at 400.

160. *Id.* See also note 158 *supra*.

161. For example, in Illinois one hundred and ten sterilizations were performed with federal funds on persons under twenty-one, even though HEW had imposed a moratorium on such funding. See note 93 *supra*. Ten of these sterilizations were performed on persons under eighteen. *Id.*

162. The signed consent form is all that is required for reimbursement. 43 Fed. Reg. 52,167 (1978) (to be codified in 42 C.F.R. § 50.204). This is HEW's enforcement provision. As an enforcement provision to ensure that necessary information is conveyed, however, this mechanism is weak.

163. The signing of preprinted medical consent forms is a virtually meaningless procedure. Testimony of Dr. Janet Winikoff to HEW, note 136 *supra*.

164. In its comments to the proposed rules, HEW indicated that requiring an "auditor witness" to the consent procedure would be a violation of the patient's privacy. 42 Fed. Reg. 62,722 (1977) (to be codified in 42 C.F.R. § 50.203). This is an unfortunate characterization. A witness would ensure that the necessary information was *in fact* communicated and understood. It is a method of enforcement which HEW fails to recognize. Instead, "[t]he Department be-

Ideally, another enforcement provision should require each agency or institution performing sterilizations to establish impartial review committees that are composed of patient advocates as well as health professionals.¹⁶⁵ These members should review the consent procedure, monitor the waiting period, and report violations to a state regional monitoring committee.¹⁶⁶ This committee, composed of representatives from community organizations and health workers not employed by the involved agency, should review the violation and take appropriate disciplinary action.

Such action, similar to the New York City¹⁶⁷ and California provisions,¹⁶⁸ should include the imposition of fines, a referral to the State Board of Medi-

lieves that while a patient should be able to have another person present during counseling and consent sessions, *respect for the patient's privacy* dictates that the presence of a witness not be mandated." *Id.* (emphasis added). HEW fails to consider the violation of privacy that occurs from involuntary sterilization.

A witness provision would guard against such violations of privacy. It also would guard against the kind of decision that was reached in *Madrigal v. Quilligan*, No. CV 75-2057-JWC (D. Cal., filed June 30, 1978). The court recognized that "whether a consent . . . was an informed and voluntary decision depended on many facts, and that a judgment could best be made by someone present at the moment the decision was made." *Id.* slip op. at 19. The court, however, stated that the attending physician was "probably" in the best position to make that judgment. *Id.* The plaintiffs disagreed. *Id.*

165. At least one patient advocate would be an attorney and another would be a community representative. The physician who was requested by the patient, an independent physician, and a registered nurse also should be included.

166. This committee would publish informational material and maintain patient information booklets in an updated fashion so that suspected and known adverse side effects and disadvantages were revealed.

167. Provisions include imposition of fines up to \$1,000.00, and legal proceedings to restrain, correct, or enjoin violations. N.Y. CITY ADM. CODE ch. 22, § C22-8.0 (1977).

Perhaps as a result of the strict penalties, the New York regulations are subject to greater attack than HEW's guidelines. Among the most outspoken opponents of sterilization guidelines, including the waiting period, was the Chief of Obstetrics and Gynecology at Bellevue Hospital—New York University Medical Center. This is truly ironic since the same institution insists on a forty-five day wait for men requesting vasectomies. Caress, *Freedom's Just Another Word for Having Time to Choose*, 77 HEALTH PAC. BULL. 17, 18 (May/June 1977). The American College of Obstetrics and Gynecology (ACOG) and the American Medical Association (AMA) oppose the regulations. Evanoff, *supra* note 71, at 20. These groups argue that the guidelines interfere with the doctor-patient relationship. The New York doctors in *Douglas v. Holloman*, No. 76 Civ. 6 (S.D.N.Y. January 1976), alleged this interference as the basis of their suit. The case was dismissed with prejudice. *Id.*

The New York City regulations are being threatened by a bill introduced into the state legislature by the Association for Voluntary Sterilization (AVS), a population control group. Evanoff, *supra* note 71, at 20. The bill attempts to change the sterilization regulations to resemble the present HEW regulations. The bill would provide for a 72-hour waiting period, no age limit (the current age limit is twenty-one), and no data collection. Mark Siegal, assembly person from Manhattan's Upper East Side and board member of the Association for Voluntary Sterilization (AVS), introduced the bill into the New York State Legislature. AVS calls it "our compromise," and Planned Parenthood is supporting it. Recently, Planned Parenthood and AVS contributed \$150,000 each and, together with bank financing, set up a \$750,000 loan fund for establishment of "mini-lap" clinics. "Mini-lap" is an inexpensive out-patient female sterilization technique (dis-

cal Quality Assurance, and possible revocation or suspension of the institution's license. In addition, the regional committee could take equitable action to restrain or correct the violations. The regional committees also should be responsible for maintaining and publishing statistics on the demographic characteristics of patients and their morbidity for use in evaluation of individual programs. On the basis of this evaluation, the committee can then take the appropriate action to correct violations or improve procedures.

CHALLENGES TO REGULATIONS: SUITS BY STATE MEDICAL ASSOCIATIONS

In enacting state sterilization regulations to prevent sterilization abuse, legislatures should be cognizant of the challenges which may be presented by various physician's associations. For example, in *California Medical Association v. Lackner*,¹⁶⁹ the California Medical Association (CMA) challenged sterilization regulations promulgated by the California Department of Health (DOH). The American College of Obstetricians and Gynecologists (ACOG) and its California constituents¹⁷⁰ filed amicus curiae briefs in opposition to the regulations arguing that they interfered with the doctor's right to practice medicine.¹⁷¹ The major issue in dispute was whether specific statutory authority existed for the regulation of medical practice.¹⁷² If "public health"

arthermy). Planned Parenthood's share reportedly comes from its fund for establishing abortion clinics. Planned Parenthood's support for the change in sterilization regulations is reportedly due to its plan to open a "mini-lap" clinic in New York City which has been delayed because it refuses to comply with the New York City Guidelines. *Id.*

168. California regulations authorize a referral to the State Board of Medical Quality Assurance. CAL. ADM. CODE tit. 22, §§ 51305.7(b), 70707.8 (1977). The Board regulates conduct of individual practitioners and judges their ability to continue holding a license when questions of performance are brought before it. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 15 (Cal. Super. Ct. April 24, 1978). California also provides for possible suspension of the hospital's license. CAL. ADM. CODE tit. 22, § 70707.8 (1977).

169. No. 268099 (Cal. Super Ct. April 28, 1978).

170. Other groups filing amicus curiae were: California Society of Anesthesiologists, the American Urological Association Inc., and Los Angeles Obstetrical and Gynecological Society, Inc.

171. An example of this alleged interference is found in CMA's belief that the regulation requiring consent information to be in the patient's primary language is a "particularly onerous requirement." Complaint in Intervention at 8, *California Medical Ass'n v. Lackner*, No. 268099 (Cal. Super. Ct. April 28, 1978).

172. Convincing DOH to adopt the regulations was no easy feat. The Coalition for the Medical Rights of Women (CMRW) petitioned the DOH in April of 1975. Although the hearings were held in May of 1975, the final issuance of the regulations did not occur until December 1, 1977. Affidavit of Mary Foran, Complaint in Intervention, Exhibit A, *California Medical Ass'n v. Lackner*, No. 268099 (Cal. Super. Ct. April 28, 1978). During the proceeding, the DOH and plaintiff doctors both played an adversarial role in relation to the Coalition's position that comprehensive regulations were needed.

encompassed sterilization abuse, then the DOH would have authority to regulate it under its general power to preserve the health of the public.¹⁷³ The court noted that health regulation statutes generally were given a broad range of conduct and upheld the regulations under the rubric of public health.¹⁷⁴

The *Lackner* court cited the two following definitions of public health as support for its finding that the DOH had such power: (1) that which the legislature deemed necessary to generally protect the public; and (2) the need to protect the public from unnecessary surgery.¹⁷⁵ Since sterilization abuse clearly fit within the perimeters of "unnecessary operations,"¹⁷⁶ the court found that the public should receive protection from such abuse. Accordingly, the court determined that the regulations sought to protect against sterilization abuse and, therefore, were within the agency's public health powers.¹⁷⁷ The court also rejected the plaintiff's attempts to characterize the informed consent procedure as a form of medical practice and thus outside the DOH's public health responsibilities.¹⁷⁸ In its discussion, the court conceded that informed consent to surgery could arise only in a medical context, but concluded that not all aspects of informed consent involved medical practice.¹⁷⁹ In reaching this conclusion, the court noted that although it was a question of professional care and a lack thereof which resulted in a violation of professional duty, the physician's judgment regarding informed consent was measured by the patient's need.¹⁸⁰ Thus, whether consent was informed was not to be measured solely by the individual doctor's determination of what was relevant information.

173. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 45 (Cal. Super. Ct. April 28, 1978). CAL. WELF. & INST. CODE § 14193 (West Supp. 1978) also authorized DOH to promulgate regulation of sterilizations for medical patients.

174. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 14 (Cal. Super. Ct. April 28, 1978). The Coalition and DOH argued that given the documented widespread abuse as a threat to public health, the DOH had the power to issue the regulations to protect and preserve the public health. *Id.*

175. The court relied on *Barkin v. Board of Optometry*, 269 Cal. App. 2d 714, 729, 75 Cal. Rptr. 337, 343 (1969), for defining "public" in public health as being broad enough to "necessar[ily] provide the protection to the public which the Legislature sought to provide." *People v. Rehman*, 253 Cal. App. 2d 119, 153-54, 61 Cal. Rptr. 65, 87 (1967), was cited for the proposition that public health is the need to protect the public from "unnecessary operations . . . which had for [its] motives avarice and greedy expectation of financial gain or other sinister purposes."

176. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 14-15 (Cal. Super. Ct. April 28, 1978).

177. *Id.* slip op. at 15-16.

178. *Id.* The doctors also argued that the regulations constituted a regulation of medical practice which only the Board of Medical Quality Assurance had the power to control. *Id.* slip op. at 13.

179. *Id.* slip op. at 16.

180. *Id.*

In its analysis, the *Lackner* court adopted¹⁸¹ the *Cobbs v. Grant*¹⁸² definition of informed consent. In *Cobbs*, the court defined the patient's need as the information material to the decision to undergo a surgical procedure.¹⁸³ The *Cobbs* court rejected the notion that physicians have unbridled discretion to withhold information from patients and defined "material" to include the procedure's potential peril.¹⁸⁴ Moreover, the court found that unlimited physician discretion is irreconcilable with the "basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected."¹⁸⁵ Finding that the physician's position as an expert required disclosure of the procedure's inherent risks and benefits, the court determined that once this disclosure was made, the expert's function was complete.¹⁸⁶ Since weighing these risks is not an expert skill, the court held that the evaluation and decision was a non-medical judgment reserved to the patient alone.¹⁸⁷ Therefore, the *Lackner* court, adopting *Cobb's* definition, found that the regulation of informed consent was an authorized regulation of medical practice.¹⁸⁸

The last major issue the *Lackner* court dealt with was whether the doctors had standing to assert the privacy rights of their patients.¹⁸⁹ In holding that the doctors did not have the requisite standing, the court distinguished the abortion and birth control cases from the sterilization situation.¹⁹⁰ The issue, as stated by the court, was:

whether, when the state determines that a particular group has abused another group, in litigation arising out of regulations which seek to miti-

181. *Id.* slip op. at 15-16.

182. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

183. *Id.* at 245, 502 P.2d at 10-11, 104 Cal. Rptr. at 514-15.

184. *Id.* at 243, 502 P.2d at 10-11, 104 Cal. Rptr. at 513-14.

185. *Id.*

186. *Id.*

187. *Id.*

188. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 16 (Cal. Super. Ct. April 28, 1978). Finally, in upholding the regulations, the court cited DOH's general supervisory power over hospitals. *Id.* Noting that hospitals could be liable for failure to provide informed consent, the Court held that such regulations were within the concerns specifically delegated to DOH. *Id.* In addition, the court found that the waiting periods and the prohibition of consent immediately postpartum or abortion guaranteed an unhurried decision. The auditor-witness and public benefits provisions were found to prevent coercion. *Id.* slip op. at 22. The court held that it was not its duty to examine the "wisdom" of the regulations. *Id.* slip op. at 13.

189. *Id.* slip op. at 28.

190. *Id.* slip op. at 30-31. The court reasoned that in each of the abortion cases, the doctor has been convicted of a crime involved in the statutory invasion of the patient's privacy. *Id.* slip op. at 30. The interests of the doctor and the patient were, therefore, identical and the doctor was the appropriate person to raise the privacy issue. *Id.* slip op. at 31. *See, e.g., Roe v. Wade*, 410 U.S. 113 (1973) (physician had two abortion prosecutions pending against him); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (physician convicted for giving a woman contraceptive foam at the end of a student lecture); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (physician convicted for prescribing contraceptives).

gate the abuse, those found to be violators may object to the regulations because they allege the violations and raise the rights of those the state seeks to protect.¹⁹¹

Given the administrative record replete with instances of doctors violating patients' rights of bodily autonomy and privacy, the court found that "the interests in the instant case were not the same."¹⁹²

Clearly the court was alluding to the record of sterilization abuse and the medical profession's active participation in that abuse. Also implicit in the court's holding is the recognition that doctors' interests vastly differ from those of their patients.¹⁹³ For example, the CMA's complaint alleged that death might occur due to a patient's fears over "unnecessary disclosures" which were not in the patient's "best interests."¹⁹⁴ It seems that the court viewed this as an attitude of paternalism which could have devastating effects. Finding oneself irreversibly incapable of childbearing after a sterilization operation would seem to cause more emotional injury than disclosure of irreversibility prior to sterilization.¹⁹⁵ Moreover, it seems that the court recognized another difference between patients' and physicians' interests. If physicians protect patients by giving them only nonthreatening information, the patient's decision is necessarily not "informed."¹⁹⁶

191. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 31-32 (Cal. Super. Ct. April 28, 1978). The court cited *People v. Solario*, 19 Cal. 3d 760, 139 Cal. Rptr. 725 (1971), in which the court held that a burglar could not raise the privacy right of a homeowner who had been the subject of the burglary.

192. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 31 (Cal. Super. Ct. April 28, 1978). It is not always clear with whose best interest the doctor is concerned. Doctors working on a fee-for-service basis have an obvious financial interest in performing sterilizations. This might interfere with the evaluation of their patient's interest and the desire to obtain a genuinely informed consent. Complaint in Intervention at 7, *California Medical Ass'n v. Lackner*, No. 268099 (Cal. Super. Ct. April 28, 1978). As Dr. Rosenfeld aptly put it, recent events have shown unquestionably that medicine, like all professions, has its unscrupulous. Rosenfeld's Affidavit, *supra* note 18, at 15.

193. *California Medical Ass'n v. Lackner*, No. 268099, slip op. at 14-16 (Cal. Super. Ct. April 28, 1978), citing *Cobbs v. Grant*, 8 Cal. 3d 229, 104 Cal. Rptr. 505 (1972).

194. Plaintiff's Complaint for Preliminary Injunction, Permanent Injunction, Writ of Mandate and Declaratory Relief, *California Medical Ass'n v. Lackner*, No. 268099 (Cal. Super. Ct. April 28, 1978) [hereinafter cited as Plaintiff's Complaint for Preliminary Injunction].

195. *Stump v. Sparkman*, 435 U.S. 349 (1978). In that case, a 16 year old was sterilized pursuant to a court order. Her mother alleged she was "somewhat retarded" and promiscuous. Linda was told she was having an appendectomy. She sued the Judge who ordered the sterilization after she discovered the true nature of the surgery. The Supreme Court held that the Judge was immune from liability. *Id.*

196. An example of nondisclosure for the patient's "protection" can be found in Dr. Winikoff's experiences as a medical student. While rotating through gynecology, she observed consistent, systematic overestimation of fibroid tumor size. This resulted in more uteri removed for "medical reasons." Patients were never told that the fibroids could be expected to shrink after menopause. Testimony of Dr. Janet Winikoff to HEW, *supra* note 136. The CMA argued that patients' rights and interests were fully protected by the existing duty of the physician to obtain informed consent; therefore, the regulations served no benefit. Plaintiff's Complaint for

CONCLUSION

Regulations aimed at sterilization abuse are necessary to ensure that persons receive *all* the information needed to make an informed and voluntary decision about sterilization. The doctrine of informed consent is indeed the explicit recognition that doctors and patients have different interests. Health care consumers must protect their interests and assert their right to decide whether or not to procure a particular health service. One such decision is whether to terminate the ability to procreate. Due to the history of sterilization abuse and the resulting loss of the individual's right to decide free from coercion and manipulation, it is time for the state to take an active role in prohibiting such abuses in this area through state regulation of informed consent to sterilization.

Preliminary Injunction, *supra* note 194, at 6. Note, however, that under this "existing duty for doctors in California an unusual number of Chicanos were told that [they] would die if they did not submit [to sterilization]." Dreifus, *supra* note 18, at 15-16. These women were misinformed, since tubal ligation is one of the few operations that is 99% effective. *Id.* at 15.

APPENDIX

Proposed Sterilization Regulations

A. Definitions

1. Sterilization means any procedure, treatment, or operation which has the effect of rendering or whose purpose is to render an individual permanently incapable of reproduction. Hysterectomy is not considered an appropriate procedure for this purpose nor should it be used for contraceptive purposes.

2. Patient means any person 21 years or older who is legally capable of giving his or her consent. No patient shall be denied sterilization because of marital status, age, or number of children. No one shall be deemed capable of giving consent unless 1) they are twenty-one years of age or older; or 2) they are under twenty-one, but such sterilization is necessary to avoid a life-threatening condition. In this instance, a second opinion from another doctor is required.

B. Conditions

1. Medical services or other benefits cannot be delayed or withheld while a person is considering sterilization.

2. Solicitation of consent to sterilization is forbidden. The operation must be requested by the patient without fraud, duress, or undue influence.

3. Initial consent may not be obtained from a female patient during admission or hospitalization for childbirth or abortion. It may not be obtained from a person whose judgment is significantly altered, whether due to medication, emotional status, or impaired sensorium.

4. Informed Consent for Sterilization requires that the patient understand the risks and benefits of all alternative, reversible methods of controlling conception. Every patient must participate in an informational session conducted by someone other than a physician, preferably a registered nurse or other properly trained individual. Every patient must be given all the information necessary and required in this section and the information which is contained in the consent form.

5. Written informed consent for sterilization must be obtained. The initial consent form must be signed by the patient, witness, and physician, after the informational session is conducted.

C. Application

This title shall apply to every sterilization performed in this state, except emergency sterilization, which is an immediate life-saving measure. An emergency which requires sterilization as an immediate life saving measure includes, but is not limited to, rupture of the uterus or uterine cancer. In all instances there should be evidence of pathology.

D. Waiting Period

A sterilization may not be performed sooner than 30 days after the initial informed consent was given by the patient.

E. Informed Consent

No sterilization shall be performed which does not meet the following conditions:

1. The patient must be informed orally and in writing:

IF YOU DECIDE YOU DO NOT WANT TO BE STERILIZED YOU WILL CONTINUE TO RECEIVE ALL BENEFITS, SUCH AS WELFARE, MEDICAID AND DISABILITY, AND MEDICAL SERVICES. YOUR DECISION WILL NOT CAUSE YOU TO LOSE ANY BENEFITS OR SERVICES. YOU CAN CHANGE YOUR MIND AT ANY TIME BEFORE THE OPERATION.

The consent form shall be signed by the patient at least 30 days after initial consent was given, indicating his or her reaffirmation of the desire to be sterilized. Such consent form shall be signed by the physician and the witness. The consent form shall contain the following information:

- a. The advantages and disadvantages of sterilization, suspected and known long term side effects;
- d. notice that benefits and services cannot be withdrawn on the basis of the sterilization decision;
- c. that the patient can withdraw consent at any time prior to sterilization;
- d. that sterilization is not reversible and that the patient will never again be able to have children;
1. This information must be in bold type on the consent form:
STERILIZATION MEANS THAT YOU WILL NEVER AGAIN BE ABLE TO HAVE CHILDREN. IT IS PERMANENT AND NOT REVERSIBLE. YOU CAN CHANGE YOUR MIND AND WITHDRAW CONSENT AT ANY TIME BEFORE SURGERY;
 - e. that the physician does not guarantee that the procedure always will be successful and occasionally it does fail; and
 - f. that the patient has a right to a second medical opinion.
2. A witness' presence is required when the patient signs the consent form and the form must be read aloud before the patient signs it. The patient will be encouraged to bring a friend or family member as a witness; but if the patient does not do so, the hospital or agency will provide one.
3. All information in the consent form and in the informational session must be communicated orally and in writing in the patient's primary language. Informed consent cannot be obtained until this is accomplished, and if this is impossible, an interpreter must be made available.

F. Informational Session and Booklet

The following must be explained orally and in writing before consent may be obtained.

1. The above two notices as to benefits, services, permanence, and irreversibility of sterilization must be given.
2. The patient must be informed of:
 - a. Alternative methods of controlling contraception and their risks and benefits, including abortion;
 - b. Alternative sterilization procedures and their attendant risks and benefits, as well as suspected and known immediate and long term side effects;
 - c. The fact that hysterectomy is not considered an appropriate family planning method; and
 - d. Her right to a second opinion if she is advised to have a hysterectomy for medical reasons.
3. The following will be discussed with respect to the various procedures:
 - a. types of anesthesia;
 - b. approximate length of time in the hospital for recovery;
 - c. whether the procedure is new or experimental;
 - d. the cost; and
 - e. an explicit offer to answer any questions.
4. All patients must reaffirm their request and consent to sterilization upon admission to the hospital or clinic.
5. All sterilizations must be reported to the State Regional Review Committee and the Office of Quality Assurance (or other state reporting agency regulating the conduct and licensing of individual practitioners).

G. Enforcement and Monitoring

1. Any person violating these regulations can be fined up to \$2,500.
2. Each facility performing sterilizations shall have a review committee composed of patients' advocates consisting of 1 attorney and 2 community representatives, and health professionals not employed by the agency involved. This committee shall review the informed consent procedure for each sterilization performed at its particular facility. The committee shall report to the Board of Medical Quality Assurance the name of any physician who performs a sterilization procedure which does not comply with these regulations. Any violation also shall be reported to the State Regional Review Committee.
3. Noncompliance with these regulations may result in revocation or suspension of the hospital or clinic's license, as well as the physician's license.
4. The State Regional Review Committee shall be composed of representatives from 4 community organizations, 4 health workers consisting of at least one registered nurse and one social worker or psychologist, and two attorneys. None of these persons shall be employed by the hospital, clinic, or physician involved.
5. The Regional Review Committee shall publish the informational booklet to be used in the informed consent process.
6. Counsel for the Regional Review Committee may institute legal proceedings to restrain, correct, or enjoin any violation of these regulations. Such actions may be entered into any court of civil jurisdiction within the state or within the review committee's region.
In such actions, counsel may apply for restraining orders, preliminary injunctions, and other provisional remedies with or without notice.
7. This state shall have a Regional Committee for every region. Each region shall collect numbers of sterilizations and record information as to age, sex, and race. These data shall be public record. Each consent form shall be reviewed for compliance with these regulations and the patient's privacy shall be protected. Every six months the Regional Committees shall conduct an audit of the individual facility review committee's records and consent forms.